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ABSTRACT

The document examines the education of health professionals in Ontario within the context of changing patterns for health care. The first of four chapters contains background information on geographic and population characteristics, Federal health legislation requiring a provincial response, and Ontario health legislation. The second chapter deals with the planning-action process for health care education. A method for coordinated planning at three levels (provinces, health science centers, and individual universities and teaching hospitals) is presented. The Ontario Health Resources Development Plan and Ontario Council of Health are described. Chapter 3 briefly discusses salient features of the health system including faults, overall scope and strategy, and basic principles. Operational manifestations, detailed in Chapter 4, cover the following areas: the focal point concept of regional organization, production and immigration of health manpower, regulation and education of the health disciplines, regulation of health laboratories and radiological facilities, future arrangements for health education, some responses of the educational system, and financing and cost. The report concludes that Ontario has made an extensive and prolonged attempt at developing a better health care system, and states four forces which set the planning-action process in motion. (Author/MS)

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# EDUCATION OF THE HEALTH PROFESSIONS IN THE CONTEXT OF THE HEALTH CARE SYSTEM : THE ONTARIO EXPERIENCE

by

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## PREFACE

Just as with so many facets of modern society, health care poses major developmental problems. Access to complete health care has come to be regarded as a right, and the last 20 years have seen an explosive growth in national systems of health care. At the present time they constitute major elements in our society, involving 4 to 6 per cent of the labour force and from 4 to 8 per cent of annual expenditure in most OECD Member countries.

Behind these signs of size and growth lie many riddles. Health care has achieved remarkable advances in terms of falling infant death rates, new treatments, and surgical wonders - yet there remain large pockets of society without adequate access to health care, and there is growing dissatisfaction with health care in its individual and human aspects. A lengthening life span and the complexities of modern society have created the need for new approaches to escalating socio-medical conditions such as ageing, chronic illness, mental illness, drug abuse, and alcoholism. To sustain the excellence of the present while grappling with these new problems, and to do so within reasonable limits of human and financial resources, is the challenge now facing the health professions.

New answers to new problems in whatever field inevitably call for personnel with different kinds of knowledge and skill. It was with this fact in mind that CERI in 1972 undertook a study of education of the health professions in the context of evolving health care systems, with the financial support of the Josiah Macy, Jr. Foundation.

The study was directed by a Group of Experts appointed by the Secretary-General of the OECD, Mr. Emile van Lennep. From the first, the Group addressed itself to certain basic questions: where are health care systems going, and why? Do these directions put new calls to our patterns for educating the health professions and occupations? Are there models of innovation that deserve to be followed up at national or international level?

The far-ranging results of the Group's study have been published under the title "New Directions in Education for Changing Health Care Systems" (OECD, Paris, 1975). Future health care, in the Group's view, will have a much stronger orientation to individualised, community-based primary health care. This reorientation will require professional

personnel with new understanding and skills in social, psychological and management areas. The effectiveness of the reorientations and the speed with which it will come hinge on new partnerships between education and health care - partnerships forged at the regional level and fostered by national and international policy clarification.

In the course of their study, the Group commissioned a number of special investigations dealing with important aspects of the health care/education interaction. The present document was prepared by K.C. Charron, Chairman, Ontario Council of Health.

J.R. Gass
Director,
Centre for Educational
Research and Innovation

## Chapter I

The first chapter of this report will deal with background material to set the stage, followed by the evolution of the planning-action process specifically directed towards the primary topic, then salient features in the health system, operational manifestations and, as a conclusion, some of the forces which set the planning-action process in motion.

## BACKGROUND

### GEOGRAPHIC AND POPULATION CHARACTERISTICS

Canada is a vast country with an area of 3,851,809 square miles. It lies north of the United States and stretches from the Atlantic to the Pacific Ocean. It is composed of ten provinces and two territories. The population in 1972 was 21,830,000 and most of it is found within 200 miles of the contiguous border with the United States.

Ontario is a very large province in the centre of the country. It is divided into Northern Ontario and Southern Ontario. The population of Ontario in 1972 was 7,825,000 and approximately 90 per cent of this total lived in Southern Ontario. Southern Ontario is highly industrialised and urbanised and this trend is continuing. Northern Ontario is sparsely populated.

### HEALTH LEGISLATION - FEDERAL REQUIRING A PROVINCIAL RESPONSE

Canada has a federal-state type of government and the jurisdictional responsibility for most health services and education rests with the provinces. The Federal Government participates in health matters in four ways:

1. Medical research is a primary responsibility of the Federal Government. It provides support through the Medical Research Council and a health research grant in the Department of National Health and Welfare.
2. Grants-in-aid to the provinces (the Hospital Insurance and Diagnostic Services Act, the Medical Care Act, and the Health Resources Fund Act).

3. Studies and investigations of matters of nationwide import supported by a National Health Grant.
4. Consultative and advisory services, particularly for the less populous provinces.

Federal participation in education is largely on the basis of grants-in-aid.

Hospital Insurance and Diagnostic Services

Federal legislation was introduced in 1958. The programme covers two components - insurance for hospital services and also for diagnostic services. All of the Canadian provinces are participating in the arrangement and approximately 99 per cent of the residents in Canada are covered. The provinces passed complementary statutes through which they entered into agreements with the Federal Government to provide a complete range of in-patient services with further extensions into the out-patient area on a voluntary basis. There is no limitation on the length of stay in hospital as long as hospital services are considered to be medically necessary. All services are covered, with the exception of those provided by the attending physician or consultants that he may call in. All general, chronic and convalescent hospitals in Canada participate in the programme. Participating hospitals are paid on the basis of approved budgets for operating costs including equipment. To qualify, hospitals must be listed in the agreement.

"Teaching hospitals are included, but major research programs in these hospitals are excluded from the cost sharing arrangements. Research incidental to service is included. In addition, financial support is provided for full-time and major part-time teaching staff for direction of services and the administrative duties they provide to the hospital."

The federal formula for making payments to the provinces is based on 25 per cent of the national per capita cost, plus 25 per cent of the cost in the particular province, less any direct charges to patients (authorised charges, deterrents, etc.). There is a waiting period of three months from the date of application to the commencement of benefits. Benefits are portable between provinces when an individual changes his residence within the country. The provinces also include out-of-province benefits for individuals who are temporarily absent. A variety of methods are used for provincial financing, such as general revenue, premiums and a special tax. These methods are frequently used in combination. Programmes are administered within the provinces by Departments of Health, Commissions and in one case, a Commissioner.

Medicare

The federal statute became effective on 1 July 1968 and all of the provinces are participating in the programme. Complementary provincial legislation was developed which includes the four requirements for federal participation:

1. Public administration - the provinces had to name a non-profit public authority to operate the scheme.
2. Scope of benefits - all services rendered by a physician that are medically required are included in the programme. This provides substantial financial support for full-time and part-time physicians on the teaching staff of clinical departments.

   A section of the Act allows these arrangements to be extended to other services but so far the only extension accepted by the Federal Government is specified dental-surgical procedures carried out in hospital.
3. Coverage - during the first year of the statute a participating province had to achieve a 90 per cent coverage of the population, and in the third year this had to be increased to at least 95 per cent. This means that the programme provides universal coverage similar to the hospital insurance arrangement.
4. Portability - participating provinces are required to ensure that there is no break in benefits when individuals move from one participating province to another.

The Federal Government introduced a new method of calculating payments for insured medical services. This was on the basis of 50 per cent of the national per capita cost.

Both of these formulae (i.e. payments for Hospital Insurance and Medicare) have a built-in equalisation factor in that high-cost provinces receive less than 50 per cent of their costs, whereas low-cost provinces receive a higher percentage.

While the majority of physicians are paid on a fee-for-service basis, the plan is permitted to arrange other methods of payment.

Health Resources Fund

Federal legislation was enacted in 1966 for setting up a Health Resources Fund to assist in the capital cost of constructing, renovating, acquiring and equipping health training and research facilities. It should be noted that this Fund is restricted to capital development. A sum of $500 million was appropriated for contributions of up to 50 per cent of those costs incurred during the 15-year period 1966-1980. Ontario would receive about $125 million and the province was expected to provide the funds to cover the rest of the cost.

Ministry of Health Act

This legislation established the Ministry, the authority of the Minister, and set up the Ontario Council of Health.

Health Insurance Act

This legislation complements the federal Hospital Insurance and Diagnostic Services and Medical Care Acts and provides authority for the province to participate in these programmes. The province has extended its programme to other services not financed by the Federal Government. These services are:

1. Examinations of the eye by refraction when carried out by an optometrist.
2. Services provided by chiropractors, osteopaths and chiropodists (podiatrists) with an annual limit on the amount of insured benefits.

Public Hospitals Act

It provides legislation for the development and maintenance of the hospital system. It deals with standards for quality of care, safety, sanitation, control in development and so forth. In addition, two-thirds of the capital cost, including start-up equipment, is paid for new construction or major renovation. Minor renovation is included in operating costs. All of the capital cost for health training and research facilities, including start-up equipment, is covered by the Health Resources Funds.

Nursing Homes Act (Extended Care Facilities)

Nursing homes in Ontario are proprietary. They must be licensed under the Nursing Homes Act and participate in the extended care programme which provides this level of care to all insured persons. The nursing home must allocate 75 per cent of its beds to extended care and at least 60 per cent must be designated as standard ward. The Act also states that nursing homes may only be developed where need for extended care beds is demonstrated.

Home Care

Home care programmes have been developed across the province with the legislative authority provided through the Ministry of Health Act.

Public Health Act

It provides the legislative authority for the public health programme. In addition, it establishes that the province will pay

three-quarters of the operating cost of public health units. Any capital development required for the programme qualifies for provincial financial assistance of two-thirds of the cost.

- Mental Health Act, Mental Hospitals Act,
- Community Psychiatric Hospitals Act,
- Children's Mental Health Centres Act,
- Children's Mental Hospitals Act.

These Acts provide legislation for the above-noted programmes. They are provincially financed.

Ontario Health Resources Development Plan

The legislation for this Plan is contained in the regulations under the Health Insurance Act. It will be described in greater detail under the next chapter of this report.

Licensing and Regulation

Ontario, as in most other jurisdictions, has a substantial number of separate statutes governing the licensing and regulation of health personnel. These statutes were developed at different periods of time. Some are satisfactory and have been kept up-to-date, but there is little in the way of consistency or uniformity associated with these statutes. The action being taken to correct this situation is set out under the chapter dealing with operational manifestations.

To summarise and analyse, this multiplicity of statutes makes it difficult to develop an integrated and co-ordinated health system. Compartmentalisation and fragmentation is inevitable. The situation is compounded in a federal-state system of government where you have complementary legislation at federal and state (provincial) level. Legislation should be consolidated to encourage functional efficiency. In the opinion of the author, Ontario could consolidate its legislation under three primary statutes covering health insurance, health services and licensing and regulation.

Chapter II

## THE PLANNING-ACTION PROCESS

### A METHOD FOR CO-ORDINATION AND PARTICIPATION

The formal planning and action process began in Ontario in 1965. The word "formal" is used, as it was recognised that we were cutting into ongoing arrangements and this feature had to be included in planning.

The basic principle which governed the approach was the acceptance, at all levels, that education of the health disciplines, health research and health services are closely related and interwoven. One of the primary objectives was to foster the development of a programme that would strengthen these ties and avoid fragmentation and compartmentalisation. However, we also accepted that the health disciplines should be educated within the general educational system for the province, while at the same time recognising the need for clinical resources, health research and so forth.

With these features in mind, we tried to develop mechanisms for co-ordinated planning. Three levels of planning were identified: provincial; health science centres and complexes; and developments within individual universities, colleges, teaching hospitals and regional arrangements (i.e. schools of nursing and laboratory technology).

#### Provincial Planning

##### Senior Officials' Co-ordinating Committee for the Health Sciences

The Senior Officials' Co-ordinating Committee for the Health Sciences was established in 1966 by the Minister of Health and the Minister of Education and University Affairs, to provide and to co-ordinate an orderly development of health education and research facilities for the province. To provide technical support to the Senior Officials' Co-ordinating Committee, a technical working party was formed with representatives from the government agencies involved in the production of health manpower. While the primary terms of reference related to capital development, the Committee, because of its composition, was the primary governmental group concerned with

the integration and co-ordination of arrangements for the education of the health professions with the health care system.

Composition

The Senior Officials' Co-ordinating Committee consisted of the Deputy Minister of Health (Chairman), the Deputy Minister of University Affairs, the Deputy Minister of Education, and the Chairman of the Ontario Hospital Services Commission. This meant that the Committee was composed of the senior officers of the departments and agencies of government concerned with education and health services.

Method of Operation

The Committee met for two or three hours almost every week for a period of six years to develop and be responsible for the development of the educational programmes for the health disciplines in the province. In addition, it assumed the responsibility for the co-ordination of interrelated features for programmes which were the responsibility of individual departments or agencies. It met on many occasions with representatives of health sciences centres and complexes and provided financial assistance and technical help in the development of programmes. The Committee sponsored the setting up of co-ordinating committees responsible for the development of integrated and co-ordinated plans for each of the health sciences complexes. The definitions used in Ontario for a health sciences complex and a health sciences centre are appended as footnotes (1) and (2). The broader base of a health sciences complex was used as the appropriate planning base for our purposes. There are five health sciences complexes in Ontario and special arrangements were made with Northern Ontario which is a large, sparsely-populated region.

The time frame for the programme was a ten-year period, with detailed plans being submitted for the first five years, along with general projections for the balance of the period. In order to permit the establishment of priorities, the approximate total amount of money available to each health sciences complex was established and the annual cash flow set out. This permitted each health sciences complex to establish priorities on a phased basis over the ten-year period.

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1) University Health Sciences Centre - is the health sciences development on campus and related developments, including teaching hospitals.

2) Health Sciences Complex - is the total unit composed of the university health sciences centre, colleges of applied arts and technology and other institutions involved in the production of health manpower within the sphere of influence of a particular centre.

During the planning-action process, it was necessary to develop a number of guidelines for the production of health manpower. These guidelines were developed and thoroughly discussed with all concerned. Three examples might be cited:

1. Production of medical manpower. The following broad objectives in terms of provincial priorities were set out for the production of medical manpower.
   a) The provincial goal for primary physician production should eventually be 50-60 per cent of a graduating class. It is recognised that this may have to be reached by stages.
   b) The training period for a family physician after graduation should be two years.
   c) The provincial priorities for medical manpower production are:
      i) to increase the production of basic M.D.'s;
      ii) to increase the production of primary physicians;
      iii) to increase the production of graduates and teachers for health manpower production programmes; and
      iv) to increase the number of specialists in areas where there is a demonstrated shortage.

   It is recognised that the need for physicians is inseparable from the need for allied professionals and health technologists, hence, similar guidelines are being applied to the other health disciplines.
2. The initial plans for teaching hospitals showed a wide variation in the allocation of space. It was necessary to develop a document setting out "Guidelines for the Assignment of Teaching and Research Space in Teaching Hospitals".
3. The education of the health disciplines was a new field for the colleges of applied arts and technology. It was a glamour area and everyone wished to participate. However, it was appreciated that this extension to colleges had to be part of a master plan and in many cases the staff and resources of the university were required for efficient programme development. This led to the development of a document which was used for planning-action purposes entitled: "Guidelines for the Development of Health Technology Programmes within the Colleges of Applied Arts and Technology and Health Sciences Complexes in Ontario".

These are three examples, and there are many more, of the learning process associated with the planning-action programme.

An excellent rapport was established between the Senior Officials' Co-ordinating Committee, the health sciences complexes and others involved in this planning-action effort. Once broad policy was established, the Senior Officials' Co-ordinating Committee had the authority to make decisions. It did not execute plans, but reviewed policy

and general proposals. Plans were developed and projects implemented by the university, college or institution concerned and reviewed by the co-ordinating committee for the health sciences complex as part of the approved master plan for that complex.

Social Development Policy

A major reorganisation of the Government of Ontario took place in 1972. An important feature of this reorganisation was the setting up of four broad policy fields within the Cabinet and one of these was Social Development.

A senior Cabinet Minister was named as the Provincial Secretary for each policy field, with responsibility for co-ordination and development. The Social Development Policy Committee is composed of the Provincial Secretary for Social Development as Chairman, with the Ministers of Health, Education (primary and secondary education), Colleges and Universities, and Community and Social Services as members. The Senior Officials' Co-ordinating Committee for the Health Sciences now works directly with the Social Development Policy Committee. The general method of operation for the Senior Officials' Co-ordinating Committee remains the same.

It is of interest to note the phased broadening of focus, starting with Health Sciences Centres to Health Sciences Complexes and now within the perspective of Social Development.

Health Sciences Centres and Complexes

As mentioned earlier, attention was focused on the health sciences centre at the start of the programme. It was considered desirable to begin in this way, as by far the largest and most complex features were associated with health sciences development on campus and related developments including teaching hospitals. The first set of plans submitted by each health sciences centre demonstrated a lack of co-ordination between the individual elements, particularly in relationship to the on-campus plans and the plans in each of the teaching hospitals. The documents tended to describe the aspirations of the individual units. This was not unexpected, as governing bodies in each case had functioned as separate autonomous institutions. This was the major obstacle in the development of integrated and co-ordinated plans. A great deal of time and effort and diplomacy was required to overcome this major impediment, but in subsequent submissions from four of our five health sciences centres the impediment was gradually removed. In the case of the fifth centre, the parties finally agreed that they were unable to establish an integrated plan and the Senior officials' Co-ordinating Committee for the Health Sciences was asked to propose a solution. The Committee reluctantly accepted this assignment, presented a solution and surprisingly it was accepted by most of those concerned.

After about two years, the planning base was broadened by accepting the health sciences complex, rather than the health sciences centre, as the area to be embraced for planning purposes. This principle again stressed the concept of a focal point, with extensions to include not only the university health sciences centres, but also colleges of applied arts and technology and other institutions involved in the production of health manpower within the sphere of influence of a particular centre. This concept in our opinion encourages a much broader involvement between educational arrangements and the health care system.

Another achievement of this type of planning was that a co-ordinating committee was established for each of the health sciences complexes and no project was reviewed by the provincial Senior Officials' Co-ordinating Committee for the Health Sciences until it had been approved by the health sciences complex co-ordinating committee. Once a project had been accepted, the usual more direct channels between departments and other government agencies were followed in order to expedite the particular programme. It was the responsibility of the co-ordinating committee for the health sciences complex to keep an eye on this development from their point of view, and the individual departments and agencies at the provincial level kept the Senior Officials' Co-ordinating Committee for the Health Sciences continuously informed on programme development. This respected normal channels of communication for operational arrangements, i.e. universities with the Ministry of University Affairs, colleges of applied arts and technology with the Ministry of Education, hospitals with the Ontario Hospital Services Commission, and other elements of the programme with the Ministry of Health.

Another feature might be mentioned. At the start of planning, it was only possible to set out guidelines and objectives for the province and the individual health sciences centre and complex in general terms. However, as planning proceeded, these guidelines and objectives, as well as priorities, could be stated more precisely and in a manner which was consistent with the potential of each area. In each case, when new proposals were made, they were put forward for discussion purposes before firm policy was established. This meant that a substantial number of people were involved in policy development.

Developments within individual Universities, Colleges, Teaching Hospitals and Regional Arrangements (i.e. Schools of Nursing and Laboratory Technology).

It was the responsibility of the co-ordinating committee for the health sciences complex to integrate and co-ordinate the planning of the individual institutions within its area. In addition, a programme concept had to be developed in recognition of multiple

involvements in a programme area. This was a formidable task which required the employment of planning consultants for the complex as a whole and the major projects within the complex. Here again, we found that this was a learning experience, not only for the planners within the complex, but also for the planning consultants. It was also our experience that no single approach was the answer, as variations in the structure and arrangements in the geographic areas called for answers which were most appropriate in each circumstance. This we considered a healthy situation, as the single model concept was not supported.

As mentioned in a previous section, one of the major problems was the autonomy of universities, hospitals and other participating bodies. It was accepted that this autonomy must be "relative" to establish a role and a place for each of the parts of the programme. This was accepted and supported in most instances, but in a few situations there was a reluctance to relinquish a particular position which had prevailed prior to the development of this programme. In these circumstances, a definite stand had to be taken which represented provincial policy on the particular subject at issue.

Clinical resources was a major matter for consideration and it was established that a substantial extension beyond the primary teaching hospitals was necessary to accommodate the various health professions. In addition, educational units were set up in the community to provide better and more appropriate arrangements for family practice and for other health professions which benefit from this type of exposure. These community health centres provided educational and service resources and are being used to demonstrate the advantages of the multi-discipline, group approach to health care arrangements. They are also being used for research in health care. The Health Resources Fund described later in this chapter was used extensively to promote this type of development.

To summarise and analyse, the planning-action process for Ontario has several important basic features:

1. Participation and involvement of all concerned.
2. An emphasis on planning-action from the periphery to the centre.
3. An initial focus on health sciences centres broadened to health sciences complexes and then to the social development field.

## ONTARIO HEALTH RESOURCES DEVELOPMENT PLAN

The Ontario Health Resources Development Plan was set up in 1969 and was identified with our Medical Care Insurance Program. Under this legislation, allowance was made for other "health benefits" and these programmes were described as follows:

a) facilities for the education and training of health manpower;
b) arrangements to obtain a better distribution of health personnel;
c) improved patterns for the delivery of health care; and
d) the promotion of regional planning and development of health services.

Such programmes constitute the Ontario Health Resources Development Plan.

### Capital Programme

Funds from the Ontario Health Resources Development Plan and the federal Health Resources Fund provide financing for the capital cost of construction, renovating, acquiring and equipping health training and research facilities. The programme has been described in some detail earlier in this chapter.

### Health Manpower Deployment

The non-capital portion of the plan includes a programme to promote the better distribution of health personnel, initially focused on physicians and dentists, but capable of being extended to other disciplines. This programme provides an array of incentives to encourage and assist physicians and dentists to establish practice in areas of the province designated as under-serviced.

As it is important to demonstrate to undergraduate medical students the advantages and satisfaction associated with family practice, bursaries to the amount of $400.00 per month are being awarded to undergraduate medical students who participate in a one-, two- or three-month summer preceptorship, under the direction of a family practitioner. A total of 45 of these summer bursaries are being awarded this year.

To assist and encourage physicians and dentists to establish practice in under-serviced areas, contracts guaranteeing net professional income(1) or incentive grants are also being offered. The contracts guarantee a net professional income of $28,000.00 - Southern Ontario, $33,000.00 - Northern Ontario, per annum for physicians, $23,000.00 - Southern Ontario, $26,000.00 - Northern

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1) Net professional income is the income remaining after deducting all allowable business expenses, but before personal income tax.

Ontario per annum for dentists. The physician or dentist retains any income accruing from practice, in excess of the contractual guarantee. As an alternative, establishment of practice grants are available over a four-year period.

Medical - Southern Ontario - $15,000.00;
Northern Ontario - $20,000.00;

Dental - Southern Ontario - $14,000.00;
Northern Ontario - $18,000.00.

Since the plan was instituted in October 1969, 165 areas have been designated as under-serviced for physicians. To date, 154 physicians have established practice as a result of this programme and 18 additional physicians have been accepted under the programme but have yet to set up practice (total 172). Seventy-five areas have been designated as under-serviced for dentists and, to date, 47 dentists have established practice under the programme.

## Demonstration Models and Pilot Projects

Increased manpower production and better distribution of health services are only part of the plan. Provision for change and innovation had to be built into the plan for the health care system. Hence, one of the main features of the Ontario Health Resources Development Plan is a programme of support for innovations and resource developments related to the organisation of health services and the provision and evaluation of health care.

The Demonstration Model Grant was established in 1969 to support innovations and resource developments related to the organisation of health services and the provision and evaluation of health care in Ontario.

Applications for support fall into the following categories:

### Demonstration Models

Within the terms of reference of the Ontario Health Resources Development Plan, a demonstration model is defined as a specific innovation in the organisation and/or delivery of health services, which is designed and executed for the specific purpose of determining its impact upon the health of individuals or groups, or upon the efficiency of the health care system. The feasibility of its replication in other locations in Ontario is important. Examples of demonstration models could range from innovations in providing primary health care through the use of allied health professionals to innovations in health services through more effective use of resources. It might be applied to any segment of health services, education or research.

Evaluation of these Demonstration Models is of paramount importance and must be clearly described. It constitutes an integral part

of a request for support of these innovations.

The funding of a given demonstration model programme will terminate at the conclusion of its evaluation. During the course of the demonstration model programme, the progress of the investigation will be reviewed on an annual basis for which progress reports may be required. Continued funding during the evaluation period will be dependent upon the demonstration of satisfactory progress.

Initial feasibility studies for the development of innovations in the organisation and/or delivery of health services, which may lead to a demonstration model, will also be considered. The criteria for determining the success or failure of the feasibility study must be described.

Resource Developments

The execution and evaluation of demonstration models demand the presence of certain resources which may be either non-existent or in scarce supply. Examples of such resources include: health care research units; programmes for the training of new types of health care professions; systems for gathering information on health care and health education as well as programmes for organising and evaluating such systems.

Awards for Demonstration Models

Since the inception of the grant programme during the fiscal year 1970-71 to the middle of the 1973-74 fiscal year a total of 76 projects for approximately 5.7 million dollars have been supported. A number of projects have already been completed and final reports are being received. In addition to the regular two review meetings of the Review Task Force, a third meeting in the fall of each year has been scheduled to review and evaluate final reports. Among the reports received are: an evaluation of five out-patient clinics using a computer simulation; a geriatric dental study determining the oral status of older persons and their attitude towards dental health; a study on children's dental visits aimed at finding the best methods of providing dental care to children; a project on team nursing to assist nursing personnel in a number of hospitals and other health agencies in Ontario to successfully implement the team methods of nursing service; a curriculum planning model for undergraduate students.

Some major studies nearing completion are: the utilisation study of the community group practice plans in St. Catharines and Sault Ste. Marie; the Burlington Control Trial on the introduction of nurse practitioners into private practice; a study on the hearing loss and hearing aid usage in the elderly; a model for a conversational computer information and statistical system; a study on the effective

utilisation of dental auxiliaries in a team approach to dental care in private settings.

Other major studies recently commenced include: a leukocyte transfusion programme by the Ontario Cancer Institute; an evaluation of pacemaker clinics; establishment and evaluation of the Donwood Institute out-patient programme, comparing the treatment of persons with drinking problems with those presently treated by the institute's in-patient programme; evaluation of an alternate treatment programme for emotionally disturbed children through the establishment and evaluation of a parent therapist programme.

Under the terms of reference for the development of provincial resources in the health care field, current support is given to: the temporal bone bank for the study into the disease of hearing and balance and the orthotic research project concerned with the application of engineering technology to the needs of crippled children.

To summarise and analyse, the terms of reference for this plan were deliberately couched in general terms to permit provincial support across the total field of health resources development. It has encouraged personnel in our health sciences complexes to become more intimately involved in the health care system, particularly in innovative arrangements. For example, the Ontario Health Resources Development Plan has supported a substantial number of innovative arrangements in the health care system and many of these are identified with educational programmes. In addition, support is available for the strengthening of units in our health sciences centres such as those concerned with health care education and research, epidemiology, biostatistics and community medicine. The somewhat slow growth of the demonstration models programme is attributed to two factors:

a) an insistence on quality and,
b) an acute shortage of trained personnel for health resources research.

The possible use of the Ontario Health Resources Development Plan as "seed money" or as a "thrust fund" will be described under the heading "Financing" in chapter IV.

## ONTARIO COUNCIL OF HEALTH

### Background

The Ontario Council of Health was established by Order-in-Council in June 1966, subsequently confirmed by the Department of Health Act 1968-69 and the Ministry of Health Act 1972. As the senior advisory body on health matters to the Ministry of Health and through him to the Government of Ontario, the Council studies and recommends

on matters which affect the delivery of health care in the Province. The manpower, facilities, and health care patterns required to provide these services efficiently to the people of Ontario are its basic concern.

Council membership consists of 17 persons, with a full-time Chairman. Members are appointed for three-year terms on a rotational basis. They are selected so as to provide reasonable balance of public interest, expert knowledge, experience and geographic distribution. A representative of the Ministry of Health serves as an ex officio member.

Duties and Role

The Ministry of Health Act 1972 defines the duties of the Ontario Council of Health as follows: "...to advise the Government and the Minister on health matters and needs of the people of Ontario and to perform such other duties as are referred to it by the Minister or the Lieutenant Governor in Council."

A corollary of Council's role as "the senior advisory body on health matters" has been the avoidance of proliferating health advisory committees unrelated to Council. As a result, Council's advisory function has embraced a wide spectrum of activity extending from advice on policy matters to the review and/or endorsement of recommendations submitted by committees otherwise unrelated to Council.

Committee Structure

Initially Council directed its attention to a number of major areas and established seven primary committees concerned with:

- Health Manpower.
- Education of the Health Disciplines.
- Physical Resources.
- Regional Organisation of Health Services.
- Health Research.
- Health Statistics.
- Library and Information Services.

The Executive Committee of Council was given the overall responsibility of co-ordinating activities and advising on priority and phasing. In addition, the importance of a variety of changing and emerging patterns in health care led to creation of a Committee on Health Care Delivery Systems in 1968. Sub-committees and task forces were established from time to time as required.

The original primary committees worked under general broad terms of reference and developed recommendations of principle and policy to serve as a basis for Council's ongoing work. By November 1970 they

had completed their initial tasks, and Council agreed to give priority to establishing standards and guidelines for the development of comprehensive health services in Ontario. To better meet this new emphasis, a revised and consolidated committee structure was approved. Under the new structure there are five primary committees. Task forces are established as required to assist the primary committees. Some have an ongoing function (e.g. research grants review); others are set up for specified periods of time to work through narrowly defined areas. In this way proliferation of task forces can be avoided, and co-ordination and concentration on specific issues can be attained within the limits imposed by time, energy and resources available.

Executive and Technical Support

Council recognised from the beginning that an essential requirement for proper functioning was suitable executive and technical support. A secretariat was created to provide administrative support and to assist in co-ordination. In addition, the Research and Planning Branch of the Ministry of Health assigns support staff to each committee and task force. Studies and provision of expertise, both from within the Branch and from outside agencies, are arranged as required.

Published Reports

The first report on the Activities of the Ontario Council of Health, June 1966 to December 1969, was published in early 1970. The report was accompanied by eight annexes, major reports in the following areas:

A - Regional Organisation of Health Services.
B - Physical Resources.
C - Health Manpower.
D - Education of Health Disciplines.
E - Library Services.
F - Health Research.
G - Health Statistics.
H - Health Care Delivery Systems (Highly Specialised Services, and Laboratory Systems).

A report on Council activities during 1970, consisting of nine supplements to the initial report, was published in 1971. These supplements consist of major reports accepted by Council on the following subjects:

1. Regional Organisation of Health Services
   - A proposed System;
2. Implementation of a Health Statistics System;
3. Health Manpower - The Need for Family Physicians, and Assistance for the Primary Care Physician;

4. Library Personnel, Manpower and Education;
5. Community Health Care;
6. Rehabilitation Services;
7. Laboratory Systems;
8. Dental Care Services; and
9. The Role of Computers in the Health Field.

The following additional reports were published in 1972:

Supplement 9A - The Role of Computers - Part II
Monograph #1 - Future Arrangements for Health Education in Ontario
Monograph #2 - Perinatal Problems
Monograph #3 - Audiovisual Systems

The 1973 publication list is as follows:

Environmental Quality
Chiropractice Practice and Education
Medical Care Insurance Review (physicians and other practitioners)
Review of Community Health Centre Project Report
Cytological Services
Parcost Review (Prescriptions at reasonable cost)
Mental Health Services Personnel (licensing and registration)
Economics of Health Research
Social Implications of Developments in Biomedical Sciences

Action has already been taken on a substantial number of recommendations of Council, and the remainder are under active review within the Ministry.

Two Committees of Council are particularly prominent in the subject under discussion: the Committee on Human Resources established in early 1971 is concerned with all aspects of health manpower and education in relation to changing and emerging patterns of health care delivery; and the Committee on Health Research has an important ongoing role with respect to general advice on policy in the broad field of health research.

Two publications of Council are particularly pertinent. The Committee on Regionalisation developed a concept of regions, with health sciences centres as focal points. This we believe to be important, as it recognises the influence the educational arrangements for the health disciplines have on the health services system. The second published document - Future Arrangements for Health Education - strengthens this concept by broadening the educational system to include satellite units. This document also stresses the involvement of our health educational resources in health services development. Several of the other reports of Council are pertinent, but these two stress important principlies which are being applied in this province.

To summarise and analyse, the Council of Health, with its committees, sub-committees and task forces, embodies the principle of what might be termed "pooling of collective wisdom and experience" so that the responsibility of advising government on all aspects of developments in health care and services, including education and research, can be shared by a large number of people, representing a wide spectrum of interest and expert knowledge. A corollary of Council's role has been the avoidance of proliferating health advisory committees unrelated to Council. Its resources are extensively used by the Ministry and the Senior Officials' Co-ordinating Committee to advise on professional and technical matters.

## Chapter III

## SALIENT FEATURES IN THE HEALTH SYSTEM

### FAULTS IN THE PRESENT HEALTH SYSTEM

The following faults might be listed:

Lack of availability and accessibility of services.

Excessive compartmentalisation and fragmentation in organisation.

A centralised rather than a decentralised administrative pattern.

Undue emphasis on ill-health rather than health.

Need to define roles of the various health disciplines and the relationship between them.

Misuse and abuse of the system by both providers of service and the public.

An educational system which has not kept up with change or prospective change in health care arrangements - it must be "out in front".

Multiplicity of health legislation.

An excessive rate in escalation of health care costs.

These faults are not peculiar to Ontario, as they will be found in varying degrees and for a variety of reasons in most jurisdictions. In listing them, it is not intended to accentuate the negative. There are many very fine features in our health arrangements and we have excellent resources of personnel and facilities. However, these faults provide barriers to the attainment of efficient, effective and economic arrangements. While they are numerous and cover a wide field, they are closely related. All are subject to solution but the solutions will depend to a large degree on the co-operation received from health professionals, the effective involvement of the public and long-term supportive government policy. The following sections dealing with an overall strategy and scope of the health services mission and with basic principles, establish the framework through which a strategic and co-ordinated approach can be developed.

### AN OVERALL STRATEGY AND SCOPE OF THE HEALTH SERVICES MISSION

An overall strategy should be developed for the health system. The objective should be to improve the health and well-being of

people. Services and programmes and solutions to problems should be assessed and analysed on the basis of potential improvements in health and well-being. Social cost should be weighed against social benefit(1). There are three primary ways to improve health(2):

a) Personal health services.

b) Environmental health (environmental control measures).

c) Health promotion (educational measures influencing behaviour).

These three primary ways should be assessed to avoid imbalances which would adversely affect the potential to improve health.

When developing the scope of the health services mission, the temptation is to include everything remotely connected with health. While it is agreed that methods have to be developed to integrate health arrangements with social services and the interrelated aspects of education, there needs to be a choice between the breadth and focus, a choice between comprehensiveness and priorities. The longer the horizontal axis, the less likely you are to have priorities and the less likely you are to have thrust(3).

There are four words that should be associated with overall strategy and the scope of the health services mission. They are: focus, priorities, phasing and thrust.

## SOME BASIC PRINCIPLES

Participation, co-operation and involvement - the triumvirate of the public, the providers of service and government.

Stress the development of a planned, integrated and co-ordinated system of health services which is effective, efficient and economic. The system must be flexible to facilitate change.

Decentralise authority and responsibility - see section on regionalisation - the focal point concept - in the next chapter.

Avoid compartmentalisation and fragmentation by emphasising a functional continuum.

Pluralism, a variety of patterns tailored to the particular circumstance which prevails.

Deprivitisation - governmental institutions becoming part of the health care system and subject to the same planning and co-ordination as applies to other elements of the system.

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1) Economics of Health Research, Report of the Ontario Council of Health, 1973.

2) Research in a Strategy for Health Improvement, by L. Breslow, International Journal of Health Services, Volume 3, No.1, 1973.

3) Organization and Administration for Health Affairs, by Wallace S. Sayre, Enquirer, Volume X, March 1973, Supplement.

Avoid the "add-on" principle by suitable adjustments within the system to accommodate any new or extended arrangements.

Emphasis on group arrangements for ambulatory care and the multi-discipline approach.

Every effort should be made to ensure that the various disciplines associated with health services are able to contribute to the maximum of their capabilities. An aggressive programme is needed to resolve the various problems associated with a team approach.

Health statistics with adequate data on "input" and "output" to permit proper planning and assessment of results.

Financing by methods which allow for cost control and facilitate the development of an integrated system.

Consolidation of legislation to facilitate the development of an effective health system.

Change accomplished through evolution, but circumstances created to encourage a rate of change which will have an early and substantial impact on the system.

The sections of this chapter could have been developed in greater detail. However, it was considered that while general features could be applied to other jurisdictions, the detailed material was likely to be specific to the Ontario setting. Furthermore, the detail was not considered pertinent to the primary subject under review in this report.

Chapter IV

## SOME OPERATIONAL MANIFESTATIONS

### REGIONAL ORGANISATION - FOCAL POINT CONCEPT(1)

Early in the considerations, the desirability of establishing a system of regional organisation of health services was accepted. This decision was based on the findings of the Royal Commission on Health Services, and on other studies related to the principles of regionalisation.

Underlying all the deliberations has been the principle that the system of regional organisation developed should provide the most effective total health service for the people of Ontario. Specifically, the Committee has considered the role of the health sciences centres as the possible focal points for the regional system, recognising that special arrangements will be necessary for Northern Ontario. In addition, consideration was given to the possible levels of responsibility required in a regionalised system, and the roles of these (the Province, the region, and the district) in the organisational structure.

The following recommendations on regional organisation were contained in two reports:

Recommendations in Report No.1

1. That the organisation and development of the several interrelated health services be carried out on the premise of providing the best possible total health services for the people of Ontario within a regional organisation.
2. That such regional health organisation should be based, in general and where specifically applicable, on university spheres of influence and interest and that every reasonable means be taken to assure that the health sciences centres of these universities are capable of assuming an active dual role in education and research, as is their prime function,

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1) Regional Organization of Health Services in Ontario - Ontario Council of Health Reports 1969 and 1970.

as well as in continuing education, re-training and service consulting in both the professional and semi-professional aspects of the total health services with which they may be totally or in part responsible.

3. That the implementation of a regional plan for total health service be based on at least two levels of authority and responsibility, the region and districts within each region.
4. That councils be established at the regional and district levels to exercise the authority and responsibility delegated by the Province.
5. That the Province have the role of providing policy guidance, of setting standards and of assessing the overall effectiveness of the system.
6. That the regional council have the role, based on provincial guidelines, of planning for the provision of health services within its region, to ensure that efficient, effective and economic use is made of available manpower, facilities and funds.
7. That the district council have the role, based on provincial guidelines and the regional planning programme, of organising the provision of health care for the residents of the district, and of co-ordinating operational functions.
8. That a detailed study be made of methods of implementing a system of regional organisation for Ontario.

Recommendations in Report No.2.

1. That regional and district councils be given assurance that every proposal for new health care facilities and services, modifications of existing facilities and additions to existing facilities, requiring financial support either capital or operating from provincial sources, shall be routed through the respective district and regional health councils for their approval or otherwise.
2. That the authority of regional and district councils be established by legislation and that the Province establish policies, standards and guidelines to provide the framework within which regional and district councils will function.
3. That regional health councils be composed of the following: the chairman of each district council within the region; a representative of the health sciences centre; a representative from regional or local government; members selected by applying the same criteria used in appointing the Ontario Council of Health, i.e. an equal number of members from the primary health professions, public interest groups, and those chosen for their particular knowledge in the broad field of health

and health services. District council representatives should total approximately one-third of the total regional council membership.

4. That the chairman of each district health council within a region should automatically be a member of the regional health council and that all other members should be appointed by the Minister of Health from short lists of nominees submitted by the relevant groups.
5. That the chairmen of regional and district health councils be appointed by the Minister of Health initially but that when the regional system is in operation the chairman should be elected by the councils.
6. That district health councils be composed of representatives from among: professional and technical interests; local government; voluntary agencies and consumers. All members will be appointed by the Minister of Health from short lists of nominees submitted by the relevant groups.
7. That the Provincial Government take immediate action to introduce a regionalised system on a phased basis with the co-operation of the people in the areas involved.
8. That the Province proceed with the delineation of regions and districts, taking into account factors such as community of interest, existing utilisation patterns, the transportation network, the boundaries of other service areas, and population characteristics.

Current Status of District Health Councils

Five district health councils have been or are being established in the province. This limited number will permit a subsequent province-wide development based on this experience. It will also encourage local initiative, with requests coming from districts for the setting up of health councils, rather than pressure from the centre.

Each district health council has approximately fifteen members, depending on the characteristics of the particular district. Five to seven members are citizens representing the broad and general interests of the population served, including one representative from the government of each of the municipalities in the district. Where there are many small municipalities, it will be necessary to share representation or rotate representation in order to ensure that other citizens are able to participate. The remaining members of local health councils are from the providers of service, voluntary agencies and social services.

An important function of a district health council will be to identify district health needs and consider alternate methods of meeting these needs. The council will plan a comprehensive health

care programme within the framework of provincial guidelines and priorities. In this regard, it has a broad responsibility to the public in the district served, both in satisfying health needs and protecting the public purse.

A district health council will integrate the operational activities of all organisations providing health care locally, to eliminate the problems caused by fragmentation in administrative responsibilities. It will have a responsibility for assuring the most efficient operation of existing, as well as future, resources. Hospital boards, boards of health and so forth will continue to be the responsible corporate body for arrangements under their jurisdiction. However, these elements of the health system receive most of their financial support from public funds and the district health council will review estimated expenditures and relate them to the needs and priorities of the district. The district health council has the assurance that every proposal for new health care facilities and services, modifications of existing facilities and additions to existing facilities, requiring financial support from public sources, will be routed through the respective district health council. Experience may dictate other types of arrangement in the future, such as a consolidation of boards or certain operational responsibilities being directly associated with the district health council. These and other features will be included and tested as innovative arrangements which will be prominent in the health resources development programme.

District health councils are part of the line structure which leads to the Ministry. In this respect, it would not be prudent, nor would it be sound administration, to have another body such as the Ontario Council of Health intrude in this arrangement. Nevertheless, there will be a need for strong mechanisms to ensure exchanges of information between district health councils and the Ontario Council of Health, particularly in relationship to planning, innovation and evaluation. This type of relationship has been tested on an informal basis by the Chairman of the Ontario Council of Health and it would appear that effective mechanisms for liaison can be established without disturbing the line relationship between the Ministry and district health councils.

Citizen Participation

Citizen participation and involvement are popular words in many jurisdictions including Ontario. Furthermore, most of these jurisdictions are engaged in trying to develop techniques which will ensure that citizens participate in a manner which results in extensive and effective involvement. None of us appear to have all the answers but we are trying.

Hospital and health boards in Ontario are in the process of change to reflect a more balanced citizen membership, rather than the boards of the past which were limited to leaders in the commercial and social life of the community. District health councils are adopting a similar approach and the Ontario Council of Health has stressed from the beginning that a substantial part of the membership should represent the public.

A problem associated with these modified and extended patterns for citizen participation is to ensure that the persons participating are able to make a reasonable contribution to the work of the particular board or council. While there have been some disappointments, results in general have been encouraging. Another feature which is supported in Ontario, is that members of boards or councils, once they are appointed or elected, do not represent any particular segment of the community but are members serving as individuals for the community as a whole.

The question which is being asked is: how do you extend these arrangements to provide an input from a more representative group of citizens? The hospitals achieve this to some extent by developing strong auxiliary organisations, but it is likely that they will represent a segment of the community which in itself is atypical. District health councils are setting up citizens' committees which broaden the base for citizen participation. In each of these circumstances, the next step may be to provide a forum for public involvement on general and specific issues.

Two other methods for effective citizen participation and involvement might be mentioned:

Health Survey of Ontario and an Example of an In-Home Public Opinion Survey

The Health Statistics Committee of the Ontario Council of Health recommended that: "a continuing health survey be conducted in a suitably designed representative sample of the population of the province; a minimum size of about 2,000 households per year is suggested. This might be carried out in co-operation with other departments of the Ontario Government or the Dominion Bureau of Statistics. From such a sample, special information could be obtained, varying in its content from time to time according to the requirements of the Department or other health agencies, on the incidence and prevalence of diseases and disabilities, on the use of health care facilities, on unmet needs for medical care, on attitudes to, knowledge about, and practices relating to health matters, and on physical and other characteristics whose relationship to health needs to be defined".

The Committee was of the opinion that: "a sample survey is the method of choice for obtaining representative data on many aspects

of public opinion, attitudes and practices related to matters important in health planning and in the evaluation of health programs". The results of this type of survey should be communicated in suitable ways to the public, so that they can be better informed on health matters.

An example of an in-home public opinion survey on a specific subject was the recent special study regarding the medical profession in Ontario. It was set up by the Ontario Medical Association to clarify or redefine the role of the profession and its relations with the public and government. While the study(1) was sponsored and paid for by the profession, the independent commissioner was given a completely free hand to conduct the study in any way he saw fit and to bring in such recommendations as he, in his sole judgement, considered appropriate. The commissioner's views on the public opinion survey are pertinent:

"The Public Hearings which were held during this Study and the invitation for written submissions (204 were received) were one way of assuring that the public could participate actively in the Study.

"But those who avail themselves of the opportunity of making a formal submission and of taking part in a public hearing are, by their very nature, an atypical sample. What they have to say, valuable as it may be, cannot be quantified; nor does it necessarily represent the views and concerns of the public as a whole.

"Early in the planning stages of the Study, it became evident it was essential that the general public of Ontario should have an opportunity to participate in the Study. The profession, the government and the Study Team should be able to hear what all the people, in contrast to some people had to say.

"It was, therefore, decided to invest a major portion of the study budget in a public opinion survey which would cut across socio-economic and geographic lines in the Province of Ontario; which would represent an accurate sample, as scientifically structured as possible, of the population as a whole.

"The findings of the Study come under nine broad headings:

- Availability of physicians' services;
- Public expectations of physicians;
- Public behaviour in regard to medical services;
- Performance of physicians;
- The social significance of physicians;
- Physicians' incomes and cost of services;
- Government involvement;

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1) Report of the Special Study regarding the Medical Profession in Ontario, submitted by Edward A. Pickering, Project Director, to the Ontario Medical Association, April 1973.

- Future developments in medical services;
- Other opinions resulting from open-ended questions.

"The Public Hearings, the submissions and the Public Opinion Survey are three different kinds of research. What is interesting is the degree to which in general, the views of individuals in 779 representative Ontario households have supported the views of those articulate and committed individuals who took the trouble to make submissions.

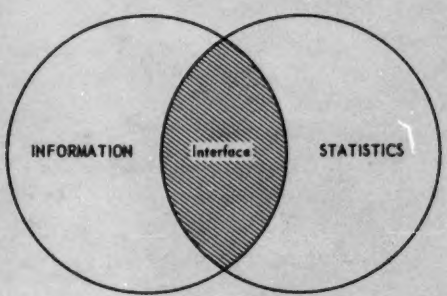
"The Public Survey has made it possible to establish that the opinion expressed in submissions, though presented from one biased position or another, did for the most part reflect public opinion. Without the benchmark of a scientific and unbiased public survey it would have been impossible to assess the value of our other research or to put full credence on it."

This study indicated that the public was interested, knowledgeable and prepared to participate. The views expressed in the public opinion survey formed the basis for many of the commissioner's recommendations to the medical profession, in its efforts to clarify or redefine the role of the profession and its relations with the public and government.

The Information and Statistical System

An efficient multi-source information and statistical system is essential to the development of effective arrangements for citizen participation and involvement. It is also important as a means of maintaining interest and ensuring that proposals are based on accurate information from numerous sources within and outside the health system. Citizen participation will wither if it is not nurtured by a good information system.

There are in fact two separate but overlapping areas of health information, namely, the different types of information required by the public and that required for the operation of the health care system. This is illustrated in the following diagram.



The Committee on Information and Statistics of the Ontario Council of Health set out the principles on which these two distinct but interrelated features could be developed to form a comprehensive information and statistical system.

Principles for Information

1. Because individuals and families should accept primary responsibility for the development and maintenance of their own health, health agencies, including the Ministry of Health, have a responsibility to provide adequate information and assistance to the individual in achieving the best possible state of health.
2. Health information programmes should be increasingly directed toward positive promotion of good health.
3. Members of the lay public, as well as health professionals, should have ready access to the health information they may seek.
4. Mechanisms should be developed to ensure the availability and dissemination of credible and accurate health information.
5. Individual agencies are more likely to be sensitive and adaptable to the information needs of their special publics than is a central body. A multi-source system also is most likely to encourage citizen participation.
6. The health information system should be a multi-source system designed for the effective sharing of health information.
   In approaching the development of such a system, one should think in terms of interrelated parts performing different functions according to the type of information involved.
7. Each part of the system must be aware of the other parts, and must be accessible and responsive to other parts of the system and individual members of the public.
8. No health information activity should be the exclusive preserve of one group, and no group should be limited in its choice of channels of communication.
   Only a multi-source system can be flexible enough to meet the many varied and changing needs. A degree of overlapping in the functioning of different parts of the system is, therefore, acceptable.
9. Guidelines should be developed to assist agencies in evaluating their health information programmes.
10. There is a need for co-ordination of, and co-operation among, the different parts of the health information system. One of the primary roles of the Ministry of Health should be to provide leadership in this regard.

One of the early steps in developing a co-ordinated health information system could be the compilation of a comprehensive catalogue of existing health information sources and resources.

Principles for Statistics

The system should:

1. Be directed toward the achievement of stated goals and objectives of the health programme and its component parts, and include a capability for ready adaptation to new and changing requirements.
2. Enable the identification of the health problems, needs and wants of the population.
3. Provide for the surveillance of the population's health problems.
4. Provide data needed for effective and efficient operation and administration of health services and programmes.
5. Provide data needed for sound planning of health services and programmes.
6. Provide data needed for evaluation of health services and programmes.
7. Facilitate the conduct of epidemiological research and other types of health research and analysis.
8. Provide for timely availability and co-ordinated and efficient flow of data.
9. Provide a potential for the linkage of information from multiple sources.
10. Be such as to ensure adequate professional skills in the relevant areas and adequate equipment for the processing, storage and retrieval of data.
11. Encourage the sharing of data, personnel, and technical resources.
12. Provide for the recording, storage and transmission of data to be controlled in such a way as to prevent unauthorised access to information.
13. Incorporate features for protecting the privacy and the legal rights of the individual.
14. Provide for alternative methods of action to achieve goals and objectives stated under Principle 1.
15. Include a central repository for all published and many unpublished but available health statistics that relate to the Province.
16. Be capable of providing comprehensive statistical services based on data of adequate quality.

17. Be co-ordinated by one agency endowed with sufficient authority to secure adherence to uniform methodological and procedural guidelines and standards.

## HEALTH MANPOWER - PRODUCTION AND IMMIGRATION

The multiplicity of studies and reports on health manpower in Canada and Ontario in recent years is an indication of its importance and complexity. While everyone points a finger at the "numbers game" in the final analysis number projections are needed to determine quantitative requirements. Changing patterns of health care, modified roles for the health disciplines, advances in technology, transfers from other jurisdictions and other factors present a changing panorama which calls for continuing assessment of health manpower. It also makes it necessary at a given period in time to make certain assumptions and base your calculations on these assumptions - one cannot continue to wait for next year's model.

In Ontario the Ontario Council of Health through its Committee on Human Resources was requested by the Minister of Health in 1971 to be concerned with all aspects of health manpower and education in relation to changing and emerging patterns of health care delivery. The Ministry and others, such as professional bodies, continue to have an input into this field.

Production of health manpower to meet anticipated need may be affected by immigration and licensing of personnel from other jurisdictions. This is a major matter in assessing need for physician manpower in Ontario and has a varying influence on manpower requirements for other health professionals.

Another important factor is the effect that increases in manpower have on health care costs. For example, in the Ontario situation with a universal health insurance programme and with physician remuneration being based largely on a fee-for-service basis, each additional physician costs the plan about $70,000 annually in direct payments for services (i.e. average gross income) and this amount is substantially increased by other physician-generated services. While human resources for health services of high quality must be provided, health planners are being subjected to careful scrutiny on manpower requests and the efficiency and economy of the system is being questioned with increasing vigour. This is a good development as long as the assessment is kept within rational limits. The danger lies in arbitrary decisions to produce a particular result (frequently a cost constraint) without an analysis of its impact on the interrelated elements of the health system.

A feature which further complicates the issue in Ontario is that in our country immigration is the responsibility of the Federal Government but licensing is controlled by the provinces. Manpower requirements, production capacity and the ability to attract health personnel varies from province to province. While a nationwide concept is accepted as the desirable goal, it is not easy to achieve. This, in itself, must be an important goal for the future.

Furthermore, the aspirations of a particular discipline do not necessarily equate to need in the health system. The tendency in the discipline is to focus on the top of the ladder and to attempt to justify upgrading without objective evidence that the public would benefit from this infusion. In fact, many examples could be quoted which would suggest that the reverse is the case. Have we overemphasised specialisation in medicine? Is the arbitrary figure that 15 per cent of the nursing force should be trained to degree level a valid assumption? Is the ratio of registered nurses to registered nursing assistants a reasonable one? Do we need more physiotherapy assistants and pharmacy assistants rather than degree trained personnel? All of these and other questions require careful answers.

While the material which follows deals with individual disciplines, it is considered that emphasis should be placed on service and programme establishments for different types and mixes of personnel. Guidelines should be developed which are sufficiently flexible to accommodate the varying situations which occur in a complex and dynamic system. This, in turn, could be translated into overall requirements which would stress the most effective use of manpower within the system as a whole.

Physicians

"In approaching the problem of adequate physician manpower in Ontario, consideration must be given not only to the total numbers of physicians in the Province, but also to the geographic distribution of those physicians according to need throughout the Province, the balance between physicians undertaking different types of general and specialty practice, the quality of the individuals and their training, cultural appropriateness and attitudes towards the pattern of health care emerging in this Province, particularly the relationships with other types of health workers. The weighting given to each of these factors, of course, will vary significantly."(1)

The substance of the above paragraph applies to other health disciplines.

Ontario medical schools (5) graduated 416 physicians in 1972 and it is estimated that 85 per cent will practice in the Province

1) Sources of Physician Manpower in Ontario - a background paper developed by Dr. John R. Evans in February, 1973.

In the same year, there were 665 registrations from other jurisdictions, with about 150 of these transferring from other provinces. Ontario has a physician to population ratio of approximately 1:600. Registration from other jurisdictions has increased rapidly in recent years. At the same time, applications for admissions to our medical schools in terms of good and acceptable applicants far exceeded the number of places available. If we increase admissions to our medical schools to provide a sufficient number of physicians to meet our own requirements, this continuing influx from other jurisdictions will overload the system. Within limits, a relative over-supply of physicians will mean a substantial escalation in health care expenditures, since it has been recognised that the number of physicians has a major effect on the costs for health services. Furthermore, an analysis of physicians from outside Ontario suggests that there is a slightly lower percentage of general physicians as opposed to specialists and there appears to be no tendency for them to locate in areas of greatest need. These facts led the Ontario Council of Health in 1971 to recommend the following principles:

1. That expansion of medical enrolment in Ontario universities be undertaken as rapidly as can be accommodated without sacrificing reasonable quality of education to achieve the manpower objectives established from time to time by the Province.
2. That, as the Ontario physician output increases, registration of physicians from out of province be limited so the total number of new registrants each year does not exceed the stated manpower objective.
3. That a committee, including minority medical representation, be established in association with the Ontario Council of Health, taking into account the policies adopted by the Council with respect to the education of the health disciplines, for the purposes of:
   a) reviewing and establishing guidelines at regular intervals on the total number of physicians required in Ontario from the combined sources of provincial production and new registration from outside the province, and
   b) indicating the methods that might be developed, if they became necessary, to maintain the appropriate number and distribution of physicians required in any field of medicine in the Province.
4. That any established guidelines restricting career choice in special fields of medical practice or the geographic location of practice for physicians who are trained in Ontario also be applied to new registrants from other jurisdictions.

5. That, when these principles have been tested in relation to physicians, consideration be given to their application to other health professions.

Concern was expressed about the implications of these recommendations in a free society, but it was also recognised that restrictions had already been placed on the number of admissions to our medical schools. These recommendations were intended to establish that the restrictions which apply to all those trained in the Province should also apply to those trained outside the Province.

The principles set out in these recommendations are being further refined to recommend a firm policy for the production of medical manpower in the Province and the licensing of physicians from other jurisdictions (likely to be available in early December, 1973).

Dentists

Our two Ontario dental schools in 1972 graduated 150 dentists (this will rise to 180 by 1974). About 91 per cent of this number will remain to practise in Ontario. There are about 60 registrations annually from other jurisdictions and about 40 of these are from other provinces. The dentist to population ratio is estimated to be about 1:2200. This manpower picture has to be viewed on the basis of the situation which exists at present and events which are pending.

Most dentists in Ontario are in solo practice and are paid on a fee-for-service basis.

The individuals who receive regular dental care usually receive a high quality service.

About 50 per cent of the population do not receive dental care, except in emergency situations. There appears to be little demand in this segment of the population for regular dental service.

Dentists are in short supply in many areas of the province, but on the other hand a substantial number of dentists in our large urban areas are not fully occupied. Even where the supply of dentists appears to be more than adequate in our present circumstances, the public complain of lack of availability and accessibility.

Ancillary personnel include hygienists, chairside assistants, dental technicians and denture therapists. They provide a valuable service and in many cases contribute to the remuneration of the dentist well in excess of the cost of their services.

A well-developed preventive dentistry programme is available in our schools through the Public Health Dental Service. The only other programme which is publicly supported at the present time is conservative treatment procedures for social assistance recipients.

The weaknesses of these dental care arrangements, even though those receiving regular dental care are well looked after, will

become apparent in the light of impending events. Pressure is beginning to develop in Ontario for a preventive and treatment programme for children, with a more comprehensive arrangement for elderly people. It will inevitably lead to a universal denticare programme some time in the future. This developing situation is being studied at present in Ontario and raises many important factors which will require policy decision.

For example, what should be the organisational pattern for the children's dental programme? It will probably be (and in my opinion, it should be) identified with school health services, to take advantage of a group situation. Any other approach is likely to lead to spotty coverage with many children not receiving regular preventive and curative services. This would defeat the concept of general improvement in the dental health of this segment of the population.

How should dentists be remunerated? For example, the preventive services in schools are paid for by salary or sessional payments. Will dentists participate and support this type of payment mechanism?

How are ancillary personnel to be used in the future with reference to the new programmes? Should the hygienist be upgraded to carry out conservative treatment procedures? Similarly, how do we make use of other ancillary personnel?

What lead-in time should be provided before the start of the programme? It should be a period of several years to allow for the development of educational and training programmes and the setting up of an efficient organisational structure. However, in practical terms, public pressure frequently dictates political decisions which force an early start on major programmes. Despite the fact that these decisions frequently lead to chaotic situations, we do not appear to profit from past experience.

All of these questions and others have to be answered, as the children's programme will probably set the stage for universal denticare in the future. Cost analyses will play an important part in the final decisions.

Nurses

In Ontario three levels of nursing education are recognised: namely, degree training in university schools of nursing (8), diploma registered nursing schools (58), and registered nursing assistant schools (53). In 1972 the College of Nurses in Ontario registered 4,679 Ontario graduates and 1,637 from out-of-province. Of the 1,637, 908 were from other Canadian provinces and the balance from other countries. The numbers registering each year from other provinces is remaining fairly constant, whereas registrations from other countries is on the decrease. It has been estimated that over 3,000 graduate nurses, chiefly from other countries, are practising nursing in

Ontario without College recognition. Many of these are ineligible for registration, primarily because their educational qualifications do not meet the standards of the Ontario College of Nurses. In 1972 the total number of new registrants for registered nursing assistants was just over 2,400. Figures are not available for out-of-province R.N.A. registrations.

The only area where continued growth in educational capacity is forecast to take place is in degree course output, which is estimated to rise from 292 in 1974 to 458 by 1980. It is considered that production levels for R.N.'s and R.N.A.'s are adequate to meet our present requirements. In fact, in many areas of the Province there appears to be an over-supply of nurses.

While the same type of analysis which was applied to physicians and dentists could be applied to nurses, it might be more appropriate to focus attention on the changing role of the nurse and in particular the expanded role of the nurse in primary health care. In Ontario, several research projects have been carried out and it is now considered opportune to go beyond the experimental approach to one of implementation. The public appears to be prepared to accept this development, most physicians and others are willing to co-operate and it has been established that quality of care will be maintained. Proposals for the expanded role of the nurse in primary health care demonstrate two important features:

1. The establishment of function and other criteria by a national committee to encourage mobility and status across the country.
2. The involvement of two licensing bodies in working out interrelated features involving both the practice of medicine and nursing.

The Expanded Role of the Nurse in Primary Health Care

In Ontario two patterns have been emerging in the past six years: first, the Registered Nurse with public health experience working on attachment to or in collaboration with the primary care physician, in group or solo practice, in family practice training clinics, or in local community health centres. The second is that of the Registered Nurse providing a broad range of services with the physician in physicians' offices, family practice units or community health centres. Both arrangements have been or are being studied(1).

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1) The Expanded Role of the Nurse in Primary Health Care - A Summary of Current Developments - Human Resources Unit, Research and Analysis Division, Ontario Ministry of Health, January 1973.

Functions as Proposed by the National Committee(1)

1. The Nurse Practitioner can be the initial contact for people entering the health care system, that is, she can be the first health professional the individual sees.
2. As first contact, the Nurse Practitioner should be able to assess the individual's health status to determine the need for medical, nursing or other intervention.
3. The Nurse Practitioner should be able to initiate treatment for patients with commonly occurring health problems which lie within her scope of competence or to arrange for the referral of patients to the appropriate health professional (or agency) as needed.
4. The Nurse Practitioner should be able to counsel people of all age groups in relation to health matters.
5. The Nurse Practitioner should be able to teach individuals and families the specific knowledge and skills they require to maintain health and prevent illness, or to care for themselves or a family member in the event of illness and assist in their recovery and rehabilitation.
6. The Nurse Practitioner should be able to undertake the care of normal healthy women throughout the maternity cycle, including antepartum and postpartum supervision and counselling and, with additional specialisation in midwifery, perform normal deliveries.
7. The Nurse Practitioner should be able to supervise the health care of well children.
8. The Nurse Practitioner should be able to supervise the health care of older people, except as they require medical intervention in the case of acute illness.
9. The Nurse Practitioner should be able to monitor patients with stabilised long-term or chronic illnesses and in consultation with the physician to adjust or modify treatment as indicated.
10. The Nurse Practitioner should be able to co-ordinate the health care of individuals and families through referral to appropriate health professions and/or agencies as needed and follow-up of patients' post-referral.
11. The Nurse Practitioner should be able to intervene in crisis situations, that is, to take action within her scope of competence or to refer the individual (or family) to the appropriate health professional or health agency for assistance.

This list of functions which the Nurse Practitioner should be able to undertake implies a much broader range of activity than has

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1) Report of the Committee on Nurse Practitioners, Department of National Health and Welfare, April 1972.

been the case in the traditional role of the nurse in primary care. It also means that the Nurse Practitioner will exercise more independent judgement than has been permitted heretofore. Although many nurses have functioned and are functioning in an expanded role in differing situations, often without the benefit of additional preparation beyond their basic nursing course, it is felt that many more nurses could be prepared and utilised as Nurse Practitioners to extend the services provided for the public in the primary care field.

The amount of responsibility the Nurse Practitioner carries, and the extent to which he or she is permitted to exercise independent judgement will vary, depending on the situation and the confidence and trust engendered in patients and colleagues.

The report also establishes criteria for the educational preparation for Nurse Practitioners, career patterns, legal implications and remuneration.

Proposals for the Recognition of these Nurses by the College of Physicians and Surgeons and the College of Nurses of Ontario

The following proposals related to the expanded role of the nurse were outlined during the summer of 1972 by the College of Physicians and Surgeons of Ontario (C.P.S.O.):

1. The training programmes and evaluation mechanisms be jointly accredited by the College of Physicians and Surgeons and the College of Nurses.
2. Upon completing the programme, the nurses be jointly recognised by the two Colleges.
3. The practice or medical authority under whose direction the nurse will be practising is to be registered for this purpose by the College of Physicians and Surgeons after satisfying criteria established jointly by the two Colleges.
4. The registered practices or medical authorities to be jointly inspected by the two Colleges.
5. The College of Nurses to have disciplinary authority over nurses practising in registered practices and the College of Physicians and Surgeons to have disciplinary authority over the medical principals of these practices, and close liaison to be established between the two Colleges on disciplinary matters.
6. The doctors in registered practices to be instructed in the relationship of the nurses who are to be associated with them.
7. For the time being, the designation "Family Practice Nurse" be applied to nurses trained as "physician associates".

The College of Nurses subsequently reviewed these proposals and proposed certain elaborations to points 1, 2 and 3 listed above.

Comments on item (1) above:

One component of the programme should deal with legal limits and responsibilities of medical and nursing practitioners.

The programmes be located in post-secondary, multi-discipline institutions where at least medicine and nursing are represented.

Comments on item (2) above:

Alternative forms of evaluation for nurses currently employed in Family Practice could be developed from the criteria in item (1) above.

Comments on item (3) above:

Other forms of sponsorship could evolve.

The statement should not limit this possibility.

One criterion might be that the doctors in registered practices be instructed in the relationship of the nurses who are to be associated with them. It was suggested that seminars might be offered for doctors and nurses engaged in Family Practice in order to strengthen the organisational structure through clarification of role expectations. Such seminars might be expanded to include other health workers employed in the setting.

Guidelines for Family Practice might be developed by the two Colleges with assistance from the College of Family Practice.

It will be seen from this reaction that the proposals are generally acceptable to both colleges, but that each is inclined to place a somewhat different emphasis on the first three items. This difference in emphasis should not impede the development of the programme.

Manpower Appraisals for other Types of Health Personnel

This report will not attempt this appraisal as the three professions dealt with above demonstrate features which are specific to a particular discipline and others which are common to many. These features will be identified with the others and the general approach as described in the preamble to the section will be important to all.

## THE REGULATION AND EDUCATION OF THE HEALTH DISCIPLINES

A Committee on the Healing Arts was set up in Ontario in 1966 and reported in 1970. Its general terms of reference was to enquire into and report upon all matters relating to the education and regulation relevant to the practice of the healing arts. The Ontario

Council of Health, at the request of the Minister of Health, reviewed the report and recommended a set of guiding principles.

The following guiding principles were endorsed as a basis for discussions in the preparing of new legislation to regulate the health disciplines and arrangements for the education of the health disciplines.

## REGULATION OF THE HEALTH DISCIPLINES

### General

1. The primacy of the public interest should be the basic principle underlying the regulation of the health disciplines. Since safeguarding the public interest is a primary concern of government, the Government must take overall responsibility for ensuring that satisfactory arrangements exist for the regulation of the health disciplines. To guarantee the competence of the health practitioner and the quality of service which the public receives, provision must be made for licensing, certifying, registering and disciplining in the overall regulation of practice of the health disciplines.
2. The self-regulatory procedures which have evolved to date should be preserved to the greatest degree possible consistent with and emphasising the primacy of the public interest and the essential co-ordination among the varied health disciplines.
3. The rights of individuals to use the services of health practitioners of their choice should be respected. Any limitations on these rights should be those designed specifically to protect the public interest.

### Role of Regulating Bodies

4. There should be regulatory bodies for all established health disciplines. The main concern of the regulatory bodies should be the interest of the public. The functions of the regulatory bodies should include the licensing, certifying, regulating and disciplining of its members.
5. The regulatory body must be independent of any voluntary association established by any health discipline, e.g. professional association, union, or trade association. Even though such voluntary associations have a concern for the public welfare, nevertheless the legal and functional independence must be complete. Under no circumstances should a voluntary association be associated in a corporate way, directly or indirectly, with a regulatory body.

Structure and Functions of Regulatory Bodies

6. In order to achieve the co-ordination which is essential for the efficient and proper regulation of the health disciplines, a Health Disciplines Regulation Board should be established by, and be responsible to, the Minister of Health with responsibility for the regulation of each health discipline, and the co-ordination of all such regulations - based on relevant health policies and health legislation. The Board should report on its activities annually to the Minister of Health, anticipating that the Minister would make the report public.

   To carry out the detailed functions of developing, co-ordinating and applying the regulation of all health disciplines, the Health Disciplines Regulation Board should make use of existing colleges and create divisions as required, to cover other health disciplines.

   a) The colleges would have regulatory responsibilities for physicians, dentists, nurses, pharmacists and optometrists. These colleges would remain essentially self-regulatory but responsive to the main intents of the regulatory structure - the protection of the public interest and the provision of a means of co-ordination of the regulations among the regulatory bodies of the health disciplines.

   b) A division would be the regulatory body for one or more related health disciplines. The divisions would have the responsibility of recommending to the Health Disciplines Regulation Board and, when approved by the Board, implementing regulatory matters relative to their particular discipline(1).

   The Health Disciplines Regulation Board should provide advice and guidance to the colleges and provide direction to the divisions, help to devise an appeal procedure and channels of communication between them and the public and co-ordinate the development and application of the regulations. The Board should be responsible through the Minister of Health for the submission of proposed legislation and regulations under the Acts for both colleges and divisions.

7. Provision should be made for the appeal of a decision of a college or division to the Health Disciplines Regulation Board. Recourse to the courts is always the prerogative of any citizen.

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1) These two paragraphs have been modified so that all disciplines will be regulated by colleges with varying degrees of autonomy depending on the maturity and experience of the discipline in regulatory matters.

8. Under the authority set out in legislation the colleges and divisions should be responsible for regulations including the licensure(1) and/or certification(2) of practitioners, for the standards for licensure and/or certification and for the discipline of their members where required. They should also be responsible for the assessment of competence of those trained outside Ontario.
9. No one health discipline should have the authority to regulate another health discipline.

Membership and Staffing of Regulatory Bodies

10. The Health Disciplines Regulation Board should be a lay Board, small in size (5-7 persons), should be composed of part-time members from outside of government service appointed on a rotating basis for a three-year term, renewable once. It should have its own full-time staff. The Lieutenant Governor in Council should appoint the Chairman and members of the Board.
11. The Health Disciplines Regulation Board should be responsible for determining the general composition and mode of selection of membership of the colleges and divisions. This should be accomplished in consultation with regulatory bodies now existing or initially with the members of a health discipline if no regulatory body exists.
    The role of the public in the regulation of the health disciplines should be recognised by having a significant number of members of the colleges and divisions who are not engaged in the health field. Such members should be appointed by the Lieutenant Governor in Council for a term of office of three years, renewable for a further term of three years.

Restriction on Licensure and Certification

12. Certification and licensure should not be restricted because of such factors as age, sex, nationality, citizenship, or length of residence in Ontario.

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1) Licensure involves the conferring on a particular person of the exclusive state-granted right to practise. Practice by any person on whom such right has not been granted is prohibited and made a punishable offence.

2) Certification involves state endorsement of competence but no exclusive right to practise. Practice by an uncertified person is not prohibited and, of course, is not a punishable offence.

Development of Nation-wide Standards for Licensing or Certifying Health Practitioners

13. It is not in the interest of the Canadian public that a variety of standards exist which impede the mobility of health personnel. Therefore nation-wide standards for licensure and certification should be developed; the Health Disciplines Regulation Board should take the initiative in promoting such standards. Nation-wide standards might be furthered through conjoint examinations as is the case in the medical profession.

Educational and Examination Requirements for Licensure and Certification of Health Practitioners

14. In establishing the educational and examination requirements for licensure and certification, a balance should be achieved between the maintenance of standards high enough to ensure quality of service yet not so stringent as to restrict the number of potentially capable practitioners who might otherwise enter the health field.

15. Graduation from an accredited or approved programme of an Ontario educational institution (e.g. university, college of applied arts and technology, secondary school, or other accepted institution) should be the main qualification for licensure or certification at the primary level for practising in the specific discipline.

16. For those graduates of educational institutions outside Ontario whose education is considered equivalent to that received in Ontario, rights to practise in Ontario should be extended through licensure or certification without the necessity of further examinations. This principle should obtain at the primary level and at the level of specialisation.

17. For those graduates of educational institutions outside Ontario whose education is not considered equivalent to that received in Ontario, rights to practise in Ontario should be extended through licensure or certification only after an upgrading of their qualifications.

Recognition of Specialisation

18. Regulatory bodies should identify and then recognise through certification only those specialties that are truly warranted.

Restriction on the Use of Title "Doctor" and Claims to Qualification(1)

19. Restrictions should continue to be imposed on the use of titles and on claims to qualification so that the public may not be misled as to the qualifications and identification of health practitioners.

Nature and Scope of Practice and the Disciplining of Health Practitioners

20. In considering the scope and nature of practice, the interdependence of the various disciplines should be stressed and increased co-operation promoted. The roles and the special responsibilities of the various disciplines in the functioning of the health team should be clarified.
21. Undue proliferation of new health disciplines in the healing arts and the unwarranted upgrading of the qualifications of the health disciplines should be avoided, since these are likely to decrease rather than increase co-operation and the effective provision of service in the health care system.
22. For the safety of the public the training for each health discipline should be such that the practitioner can perform the diagnostic and/or therapeutic procedures authorised for that discipline. At the same time undue restrictions should not be imposed on the scope or place of practice, since such restrictions could limit the availability and accessibility of health services to the public.
23. Improved procedures should be instituted which would reduce misunderstanding between patient and health practitioner with respect to such matters as extent of services required, appliances required, and cost of service.
24. In cases where common procedures lie within the scope of two or more health disciplines, the pertinent regulations should be co-ordinated.
25. Although the regulatory bodies are responsible for the standards of practice and appropriate disciplinary action with regard to members of the respective health disciplines, it should not be their responsibility to enforce the prohibition of practice by an unlicensed person. This responsibility should lie with the Minister of Justice.

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1) This matter is still under discussion and has not been resolved.

Responsibility

26. The education of all health workers should be the responsibility of educational rather than regulatory bodies. In the university-educated professions, the university should be primarily responsible for the relevant academic programmes. The educational programmes for other health disciplines should be the responsibility of those bodies charged with the Province's educational programmes under the Minister of Education.
27. To advise on health disciplines courses in colleges of applied arts and technology, the Minister of Education should establish a Committee on Health Disciplines Education consisting of five part-time members outside of government service, for a three-year term, renewable once. The Committee should have the power to call in, on an ad hoc basis, members of the occupations whose educational programme is directly affected, as well as members of related occupations where applicable, and other individuals who are capable of contributing. The Committee's function should be to advise on matters such as curricula, length of programme, and training standards for each health discipline.
28. In implementing their responsibilities, the educational bodies should work in association with the regulatory bodies.
29. The Department of Health and its associated bodies should be responsible for providing information for planning educational programmes. This information should include determination of present and future needs for health manpower, and determination of the roles of the various disciplines that are, or will be, required to maintain the health care programmes of the Province.

Entrance Requirements

30. Entrance requirements should not be so rigid or so demanding that they prevent potentially able health workers from entering educational or training programmes in the health disciplines; the tendency to increase entrance requirements for these programmes without valid justification should be discouraged. (See also Ontario Council of Health policy recommendation regarding training and education of health workers, O.C.H., Min.191.2, January 1970, which supports this principle).

Length of Programmes

31. Educational programmes should provide students with the necessary skills and knowledge to function adequately in a professional or other occupational setting. The tendency to augment the length of educational programmes without sufficient justification should be resisted.

Establishment of Programmes

32. Educational programmes for health workers should be established in educational institutions of an appropriate level. In general, programmes for disciplines requiring degrees should be established in universities, and programmes for other health workers should be established mainly at colleges of applied arts and technology or other suitable educational institutions. Based on the premise that there will be close co-operation in the provision of clinical resources, educational and training programmes presently conducted in hospitals and other health service institutions, as well as some forms of apprenticeship training, should be, in general, centred in (i.e. should be the basic responsibility of) educational institutions. (See also principle on Clinical Resources, and paragraph 3, page 108, Vol.3, Report of the Committee on the Health Arts, which enlarges upon the role of clinical education and experience in the hospital.)

Clinical Resources

33. Adequate clinical resources are essential and must be made available to students proceeding through an educational programme and apprenticeship, and for internships when required. There should be close co-operation between the educational institution and the service institution to ensure that clinical resources are available before educational programmes for health disciplines are instituted or modified Such co-operation should continue after the establishment of a programme. On the other hand, clinical resources should not be overused, and internship programmes should be no longer than necessary. There should be overall provincial and regional co-ordination in the effective use of clinical resources.

New Programmes

34. Educational programmes at all levels should be able to provide for an adequate number of personnel in any given discipline to meet existing and projected manpower

requirements. Where this is not the case, new programmes should be developed or existing programmes expanded to meet these requirements. Also, programmes should be developed in appropriate educational institutions to train health workers in these new fields as they are required.

Specialisation and Advanced Training

35. Educational programmes for specialisation and advanced training programmes in the health disciplines should be directed toward the total provision of an adequate number of personnel in each discipline to meet existing and projected manpower requirements. When it is deemed necessary, new programmes should be developed or existing programmes expanded to meet these requirements.
36. Determination of manpower requirements in specialty areas should include an assessment of whether specialists in the area would contribute to improved health services. In this respect, the unnecessary proliferation of specialties and sub-specialties should be avoided.
37. The responsibility for projecting manpower requirements for specialists should rest with the Department of Health and its associated and advisory bodies.

Curriculum Content

38. In order to improve the educational programmes of the health disciplines, the health care delivery systems and preventive and social aspects of health care, as well as the integrated teaching of science should become an integral and balanced part of the student's curriculum. At the same time, the necessity for co-ordinating the activities of all health and welfare workers should be stressed.
39. In order that students in various health disciplines can be brought together, common courses in health disciplines, where applicable, should be introduced in universities and colleges of applied arts and technology.

Continuing Competence and Retraining or Refresher Programmes

40. Practitioners in all health fields should be encouraged to maintain a high level of competence by participating in continuing education programmes which would keep them up to date with new developments in their respective fields of health care.
41. Everything possible should be done to find adequate ways of implementing a method of ensuring continuing competence

which eventually might have to become a condition for re-licensing.

42. Retraining or refresher programmes should be made more available to all categories of health workers, especially to those in disciplines where a specialty has become obsolete or where manpower needs would make it advisable that sizeable numbers of inactive personnel trained in a discipline be recruited back into the work force.
43. The universities or other appropriate educational institutions should be responsible for the content of the retraining or refresher programmes and the programmes for ensuring continuing competence, while the appropriate regulatory bodies should be responsible for assessment of competence. Close co-operation between these respective bodies, however, is essential. Service requirements should also be identified and included in this process.

Accreditation

44. To ensure that the public has a high quality of health care, systems of accreditation or appraisal should be continued in, and/or expanded to, those institutions where practitioners in the health disciplines are educated.
45. Accreditation or appraisal should be the responsibility of a body independent of educational institutions, regulatory bodies or voluntary associations.
46. Universities with health sciences complexes should encourage the creation of a Canadian accreditation or appraisal system for the health disciplines trained in their health sciences complexes.
47. Nation-wide standards allowing inter-provincial mobility should be encouraged.

Teaching

48. In order that all essential disciplines of the health care team may attain the highest competence and degree of co-operation, members of one health discipline should be permitted and encouraged to participate in the educational programmes of other health disciplines.

Education for Manpower Supply and Recruitment

49. There should be an adequate supply of qualified practitioners in all essential health disciplines to meet the needs of the community. Facilities and programmes should be created and/or maintained to educate and train an adequate number of

practitioners to meet the health manpower needs of the Province.

Capital Development for Education

50. Before additional facilities are established for education in the health disciplines it should be made certain that full utilisation is being made of existing facilities and resources.

REGULATION OF HEALTH LABORATORIES, RADIOLOGICAL FACILITIES AND POSSIBLY OTHER HEALTH FACILITIES

51. The primacy of the public interest should be the basic principle underlying the regulation of health laboratories, radiological facilities and possibly other health facilities. It is the responsibility of government to ensure that satisfactory arrangements exist for the regulation of these health facilities.
52. To guarantee the competence of the supervising personnel and the quality of service which the public receives, the licensing and regulation of independent health laboratories, radiological facilities, and possibly other health facilities which provide services to the public, is necessary. The Department of Health should assume responsibility for the licensing and regulation of such facilities.
53. In establishing the requirements for licensing, a balance should be achieved between the maintenance of standards high enough to ensure quality of service, yet not so stringent as to restrict unduly the number of facilities which can make these services available.

Omnibus legislation is being prepared to cover all health disciplines in one statute. It is a good example of consolidation of health legislation (another is the bringing together under one statute of the health insurance programmes in Ontario).

FUTURE ARRANGEMENTS FOR HEALTH EDUCATION(1)

It might be appropriate to quote the summary of this report:

Summary

For the foreseeable future, the type of health care system in Ontario will be largely determined by the attitudes and the number of doctors available. The education of health personnel is a major

1) Future Arrangements for Health Education, an Ontario Council of Health Report, 1971.

factor in determining the number of doctors available and important in determining attitudes. There is a need to develop educational programmes that have strong links with district and regional health systems to maintain a positive influence on education in community health problems, the distribution of physicians and other health personnel, and continuing education.

The Task Force recognised that changes were taking place in the delivery of health care. Educational programmes are playing a part in these changes, and changes which are successful will have a significant influence on educational programmes. It is essential that any developments in health services and in the education of health personnel maintain high standards of health care.

Arrangements for the education of health personnel in Ontario could follow a number of routes. A new health sciences complex could be built to increase the output of manpower for the system. The existing health sciences complexes could be expanded and encouraged to develop a community base to better integrate their educational programmes with the health care needs of the community. Increased numbers of health personnel must be educated to meet the needs of the health system.

> The Task Force believes that the most effective solution at present is to provide resources for the existing health sciences complexes to develop expanded educational programmes. Valuable components of existing programmes should be maintained and their base of education extended into the communities through the concept of satellite education centres.

Two major factors affected this conclusion. First, the Task Force believes the existing five complexes can expand sufficiently to maintain the present ratio of health manpower to population for a substantial number of years. Second, the structure and motivation of professional health education can play a major part in improving the distribution and delivery of health care.

Health Manpower

Doctors are a critical component of the health manpower team and the supply of doctors is a good measure of the adequacy of our health education system. There are about 10,000 doctors in Ontario, providing a doctor-to-population ratio which compares favourably with other countries with a similar standard of living. The annual attrition rate of Ontario doctors is about 3 per cent and the provincial population grows about 2 per cent each year. Accordingly, Ontario will need to add new doctors at an annual rate of roughly 5 per cent of the doctor population if it is to maintain its current proportion of doctors to population.

The present output of the health sciences complexes in the province is equal to about 3.5 per cent of the number of doctors in Ontario. If the output of the existing complexes is increased as currently planned, output will rise to about 5 per cent. If the existing health sciences complexes adopt the plan proposed in this report the figure could rise to about 8 per cent of the existing physician population. It is clear that our present facilities can be made to maintain the current favourable doctor-to-population ratio for the next 15 to 20 years without adding a further health sciences complex.

At this time Ontario trains doctors at a rate relative to population which is higher than most of the developed nations. Furthermore, although we enjoy a high rate of doctor immigration, it is evident we will not need it to maintain our favourable proportion of doctors-to-population if the proposals in this report are accepted. However, while the doctor-to-population ratio would be favourable, the maldistribution of physicians and other health personnel leads to local shortages. This feature will require continuing effort to correct.

As noted below, increased efficiency in making use of health personnel should contribute significantly to improved delivery of health care and may be as important as improving the doctor-to-population ratio.

Health Education and Health Care Delivery

At present very little education of health personnel takes place in community settings other than active treatment hospitals. In view of the importance of other sectors in health, it is essential that the health sciences complexes develop programmes that give balanced emphasis to all aspects of delivery of health care and community health problems.

While it would be easier for a new complex to be organised to orient professional training to balanced community health care needs, it would take at least ten years for the new complex to have any real impact. Even then, the output of doctors from this school would be less than 1 per cent of the Ontario doctor population. Furthermore, there is already evidence that the existing health sciences complexes are developing plans and programmes along these lines, and it would appear to be wise to capitalise on this initiative.

To make a major impact, it is essential to develop health personnel capable of dealing with the problems in the health care delivery system. These problems include new arrangements for delivery of health care in the communities and effective use of "all" health personnel. So it would be more appropriate to commit resources to the present health sciences complexes allowing them to expand and develop community-oriented educational programmes.

Arrangements for Education of Health Personnel

Community health problems must be a major concern of the educational system and it must provide appropriate clinical training. It is recommended that the existing health sciences complexes take part in the development of satellite educational centres involving hospitals, clinics, doctors' offices, and other health units. This should be done within the district and regional organisation of health services as proposed by the Ontario Council of Health (focal point concept). If the recommendations are implemented, the capacity of the complexes for the education of health personnel could be more than doubled.

To reach this objective, increased staff will be required for all the established health sciences complexes; teaching areas will have to be added to the satellite education centres and some of the existing facilities expanded. The capital cost of expansion of the capacity of the present health sciences education system by this means will be less than the alternative of building a sixth complex. Though it costs as much, it will have the advantage of greatly improving community health care delivery. It is essential that the universities and government jointly establish a control mechanism to ensure that the resources are used to achieve these essential health care delivery and manpower objectives.

This proposed programme must not be interpreted to suggest that the health sciences complexes forsake scholarship for a frontal attack on the immediate problems in health care. The challenge to government and the health sciences complexes is to resolve the dilemma, not by giving one course of action priority over the other, but by blending them into an effective programme.

The recommendations were as follows:

Recommendations

1. That no new health sciences complex be built until the capacity of existing institutions has been fully developed and attempts have been made to integrate health education and health care delivery.
2. That necessary resources be committed to the established health sciences complexes so that they can begin developing and implementing the programmes that are necessary for new developments in health education and health care delivery, and that this have the highest priority in the utilisation of resources.
3. That these new developments include the establishment of satellite health education centres (involving hospitals, clinics, doctors' offices and other health units), within

the guidelines for regionalisation recommended by the Ontario Council of Health, so as to provide (a) a base for health education oriented to community health problems, (b) an increase in clinical facilities (including ambulatory care) for the education of health personnel, and (c) an increase in resources for continuing education of health personnel, so as to provide first-rate services integrated with the educational programme.

4. That the satellite education centres be distributed and organised so that they can exert a positive influence on the selection of students, the regional distribution of health manpower, and the participation of users of health services.
5. That the health sciences complexes maintain their educational programmes as far as is possible on a year-round basis, with the objective of reducing the length of time required to graduate individuals from the programmes and to attain maximum utilisation of personnel and facilities.
6. That, in implementing these new programmes, it is essential that the universities and government jointly establish a control mechanism to ensure that the resources are used to achieve these objectives.
7. That new arrangements for funding the operating portion for the education of health personnel, including the associated clinical services within the health sciences complexes, be established.
8. That, in keeping with the guidelines for the development of health technology programmes, there be established in respect to the education of health personnel in each region a regional advisory planning committee for the health sciences complex (composed of representatives from the health professions, education, government and the community).
9. That, in order to improve the mobility of students in the various health education programmes and the efficient use of resources, the educational programmes of the colleges of applied arts and technology, schools of nursing, and universities, be closely integrated.
10. That the government and universities recognise, in the development of new programmes, that the established function of the university in scholarship and research should be maintained and that success will be achieved only by blending new programmes with the scholarship and creativity within the university.
11. That, at regular intervals after the initiation of a new programme for the education of health personnel, the situation

be reviewed by the Ontario Council of Health in respect to the progress made by the established health sciences complexes and the organisation of health services by community groups. The philosophy set out in this report is being followed in Ontario.

## SOME RESPONSES OF THE EDUCATIONAL SYSTEM(1)

Dr. H. Rocke Robertson, formerly the Principal and Vice-Chancellor of McGill University, has recently completed the study noted in the footnote to this page. This section will quote extensively from Dr. Robertson's study and quotations will be appropriately identified.

a) Improved Co-ordination in Planning for all Post-Secondary Education

The reader is referred to Chapter II, the Planning-Action Process. The primary purpose of this chapter is to describe a mechanism for improved co-ordination and participation for post-secondary education as it relates to the health sciences.

b) Admission Criteria

The health disciplines are popular in Ontario and it can be said that in most circumstances the number of highly qualified applicants far exceeds the number of places available. Admission in the past was largely based on academic qualifications, but other criteria are now being used, such as motivation and experience. The application of these criteria to one of our schools of medicine (McMaster) was described as follows:(2)

> "Another aspect of mobility is the broadening of admission requirements to highly sought after fields of health education such as medicine. Until recently nurses or social workers who subsequently decided they wished to enter medicine were effectively excluded because of lack of sufficient depth in training in chemistry and biological sciences. Now admission requirements have been broadened, at McMaster, so individuals with established learning ability and favourable qualities of character may enter medicine directly without the normal academic requirements in physical and biological sciences. This opens the medical door much wider to other health professionals. It also serves as a means to offset the forces of academic competition which deny admission to highly committed individuals whose earlier formal

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1) Health Care in Canada: A Commentary, by H. Rocke Robertson - Background Study for the Science Council of Canada, March 1973.

2) Co-ordination of Educational Programs - by John R. Evans, 2nd National Conference on Health Manpower, Ottawa, October 21, 1971.

educational opportunities have been handicapped by ethnic background, poverty, or inadequacies of the educational system in the remote geographic areas in which they have lived."

Another criterion is the community of origin of applicants where preference is given to a number of applicants from our smaller and more isolated communities to encourage the return of health personnel to these underserviced areas. These and other criteria will undoubtedly assume greater importance in the selection of applicants in the future.

c) Undergraduate Education

A few trends are:

i) "The first to be noted is that of the increasing interest of both teachers and students in reassessing what, how and why things should be taught; and in redefining goals."

ii) "Of more immediate importance than the goal setting are the efforts being made to find the core of knowledge that all students should master no matter what their eventual niche may be; to present this core in the most easily assimilable form (thought to be in the 'systems' approach) and otherwise to encourage the student to follow his own bent, to choose, from the elective studies open to him, those that interest him most and from which, therefore, he will derive the most benefit."

iii) "A new option widely open to the medical student, and often strongly urged, is to concentrate heavily on the problems of Family Practice. This, too, is good; it should lead to the closing of a well recognised gap in our pattern of medical education."

iv) A greater emphasis on prevention and health maintenance.

v) Community health centres and clinics and group practice settings as locations for undergraduate and postgraduate education.

vi) A stressing of the social sciences. "Balanced support of the social and the technological sides of health care is what we need, not a swinging of the pendulum from one to another."

vii) The development of a strong research and development capability in our health sciences complexes, with greater student involvement in practical health care organisation problems.

viii) An interest in our two schools of dentistry to establish clinics in teaching hospitals and community health centres, rather than perpetuating the large central clinical resource in faculties of dentistry.

ix) Traditional programmes of nurse education at diploma level are being placed in our colleges of applied arts and technology, with practical experience in hospital and ambulatory care settings.

d) Emphasis on Continuing Education within the Broader Context of Recurrent Education and with Linkages for Relicensure and Recertification

The five medical schools in Ontario are placing a much greater emphasis on continuing education. Each school has a department of continuing education with, in most cases, a full-time director. Similarly, our two schools of dentistry have departments of continuing education with full-time directors. A wide variety of programmes is offered and certain opinions are beginning to emerge.

The Refresher Course

"It is generally conceded that the value of the standard 'refresher course' lasting 2 or 3 days is not great. Nor can it be expected that slide shows, films, ratio and television courses, interesting though they may be and useful for this reason, will have a profound effect. Some of the areas that are now being explored and in which, it is hoped, further development will take place are as follows:"

Peer Review

"There can be no more effective educational process than Peer Review: in connection with a 'medical audit', be it in a group practice or a hospital, a review with one's peers of the work done, involving frank discussion of errors and analysis of cases of interest."

An unfortunate feature is beginning to creep into our medical arrangements in large metropolitan areas. Because of the concentration of physicians in these situations, an increasing number do not have a staff appointment to a hospital. Many of these physicians are in solo practice or very small groups. In these circumstances, it is more difficult to establish peer review arrangements and it is likely that a closer scrutiny will be required of the work carried out by these physicians in the future.

Visiting Teaching Teams

"Regular visits of teams from a university to regional hospitals to give courses and to have discussions on subjects suggested by and in a manner planned in co-operation with, the local group. In fairly extensive experience with this method those responsible for it have become convinced that active participation of the 'students' in this

way has played a vital role in the sustained success of these courses."

Prolonged Courses in Hospitals

"It seems evident that periodic return to the hospital or clinic for a suitably long period (2 or 3 months) would be the ideal form of continuing education. Freed from his practice a doctor could devote his full attention to learning and, given suitable arrangements in a hospital or clinic, which should be easily effected, he would be in the best possible position to make up whatever he had lost or missed in his years away. Where doctors are practising in sizable groups it can be arranged that at any one time a member of the group can be away being refreshed. His colleagues fill in the gaps that he leaves, and neither the extra work for each nor the cost is great. In smaller groups and in the case of the solo practitioner, it may be virtually impossible for a doctor to arrange to leave his practice to take a prolonged course.

"Some interesting trials have been carried out in which teams of students and interns from hospitals have 'taken over' a practice to, it is said, the satisfaction of everyone concerned, while the doctor was away. It is conceivable that the method might be widely adopted although the arrangements are likely to be difficult."

Self-Assessment Programmes

The College of Family Practice has set up a system of self-evaluation based on answers to multiple-choice questions. This will establish a profile for the particular physician and identify weaknesses in particular fields. The College then recommends reference material and courses of action to strengthen these weaknesses. While this is a voluntary programme at present, it could lead to a method of assessing competence, possibly associated with relicensing in the future. This same type of approach could be applied to the specialties.

"It is clear that those involved are just beginning to crack the surface of the problems of continuing education. A good start has been made by the establishment of machinery in the Medical Schools for stimulating, organising and co-ordinating the work in this area. But there is a long way to go.

"There still remains a lot of co-ordinating to do. Medical schools, medical associations, specialist associations, hospitals, etc., are all involved and the proper liaisons have still to be worked out in most places.

"Ways must be found to encourage a much higher proportion (and it should be 100 per cent) of practitioners to participate. An

important aspect of this, it should be repeated, involves the question of covering the doctor's practice while he takes a course."

It seems inevitable that a system of relicensure and recertification will be introduced at some time in the future. In this regard, a proposal in Dr. Robertson's report is of interest.

"We suggest, in summary, the following which involves in essence the bringing together for consideration by an appropriate Board of all the information on a doctor's work that is now available in many places.

1. That the performance of each doctor in practice be formally reviewed every five years by a Board(1) appointed for each region in a manner agreed upon by the appropriate governments and by the College of Physicians and Surgeons.
2. That the practice of including lay persons on these Boards (as they have been on Complaints and Discipline committees in some of the Colleges) should be followed.
3. That the Board have available to it:
   a) Information from the hospitals in which the doctor has worked; this information would include a report from the chief of the service or services to which the doctor had admitted patients; from the medical audit, tissue and utilization committees;
   b) The results of examination of his Medicare profile;
   c) A statement from the College of Physicians and Surgeons.
4. If these data cast no doubt upon the doctor's ability to practice he should be recertified.
5. If there was a reasonable doubt, a full examination of his work in his office and the hospital should be undertaken.

"It is clear that in many respects the method is crude, but with practice it could, no doubt, be refined. The principle of 'examining' a doctor on the basis of his performance in practice is, in our view, sound; indeed we believe it to be the only way of judging a person for such purposes as recertification.

"We are not prepared to suggest a technique by which dentists or other health workers might be examined. We do maintain, however, that the principle of periodic assessment should obtain throughout."

e) New Patterns of Education-Service Interaction

The reader is referred to the material in this chapter under "Future Arrangements for Health Education" and the description of the Ontario Health Resources Development Plan in Chapter II.

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1) The number of Boards in each region would depend on several local factors, i.e. the number of doctors, of specialties represented, etc. An objective would be to have it so that each Board would be competent to judge on the individual case.

f) Expansion of Research Efforts relating to Health Care Delivery

The reader is referred to the Ontario Health Resources Development Plan in Chapter II.

## FINANCING AND COST

Both education and health are being subjected to relatively severe financial constraints and this situation is likely to persist.

### Financing of Post-Secondary Education

The primary method for financing post-secondary education in Ontario is through formula grants based on the number and types of students. There is a weighting factor for the different types. This method of financing seems to work reasonably well for most aspects of post-secondary education, with the chief criticism being directed toward the difficulty in projecting numbers so that any shortfall leaves the institution with a surplus of staff. While this formal method is able to accommodate the education of the health disciplines for academic subjects and graduate education, it does create major problems when applied to clinical arrangements and postgraduate education. The Senior Officials' Co-ordinating Committee (referred to in Chapter II) had many discussions, and sometimes these were acrimonious, on whether or not the health disciplines had features which were peculiar to these disciplines. I believe it was finally recognised that there were differences, but probably not as prominent as those of us in the health fields described at the start of the discussion. Five points in which the health disciplines differ from other parts of post-secondary education are:

a) Government is the manager and primary source of funds for a large, complex health industry. Manpower needs are dictated by the health system and the public considers that health services are a right.
b) Clinical departments are enmeshed in service programmes and a substantial part of the effort of these departments is directed towards maintaining excellence in quality of care.
c) Specialty training is controlled by the Royal College of Physicians and Surgeons and not by the educational authority.
d) The health sciences complexes are the focal points of the health system. They must become increasingly involved in health care arrangements. Personnel in the complexes are a major source of research and development capability for the regionalised system.

e) Health research is supported by the Medical Research Council, federal health grants, and a provincial health grant. Research in hospitals incidental to service is financed through health insurance. Here again, research is enmeshed with education and service.

Other points could be mentioned, but the ones listed indicate that there are major differences. This is not to imply support for the separation of the health sciences from the educational system. Rather, it is a plea to recognise some of these differences and probably provide the financial support for these features from another source which will not further encroach on available educational funds. For example, if the health system require additional service, it might be appropriate for the system to purchase it from our health sciences complexes.

Financing of Health Services

The Federal Government provides financial support for health services through its health insurance arrangements, the National Health Grant and health research funds from the Medical Research Council and the Department of National Health and Welfare. Provinces provide financing for health insurance arrangements from funds in general revenue, retail sales tax usually identified for the purpose, and premiums. Ontario supports the health insurance programme by funds from general revenue and premiums. In addition, provincial governments provide grants for programmes such as public health, mental health, home care, etc., usually on the basis of an approved budget.

In total, public funds from federal and provincial sources pay for about 80 per cent of the total cost of health services. The only two major programmes outside this public system of support are dental services and drugs and biologicals.

Up to the present, the approach has been a categorical one to provide financing for specific services such as hospital insurance and diagnostic services, medicare, public health and so forth. The Federal Government is at present attempting to negotiate an arrangement which would provide funds which could be used in any part of the health system and this trend may be followed by the provinces. It will make it important to define the salient features in the health system and the overall strategy and scope of the health services mission. In this regard, focus, priorities, phasing and thrust become extremely important (see Chapter III).

Cost of Health Services

The costs of health services in Canada and Ontario are enormous and are escalating at a rate which outpaces available sources of revenue. This is a feature which is common to many countries. For

example, in Canada in 1967 it was estimated that health services cost $3.7 billion and in 1967 that this cost might reach $6.2 billion in 1972. In recent years health care costs have been rising at an annual rate of more than 10 per cent, with hospital services costs rising at a rate of 14 per cent. While financial constraints have resulted in some levelling off of this rate of escalation, it still outpaces available sources of revenue.

It is generally recognised that there are many inefficiencies in the system and these must be corrected to bring about a satisfactory cost picture. The two major components which have to be corrected are the increasing costs related to institutional care and physician services. There are other offenders, but these are the two major contributors.

Constraint patterns which have already been applied would indicate that global systems of budgeting are likely to develop, under which escalation in costs will be controlled to a fixed amount. A global budget would probably be applied to the major elements, such as health facilities and physician services, with the constraint pattern extending down to the budgets of individual institutions and the remuneration being received by individual physicians. If such a pattern develops, there will be a need for separate funds which could be identified as "thrust funds", "investment funds" or "seed money". The Ontario Health Resources Development Plan is a good example of a thrust fund, as it is being used to bring about changes in the system. If such funds are not created and set aside for these purposes, it will be very difficult to bring about the changes which are so urgently needed. This proposal, then, suggests that financing health services in the future be provided by funds set up for two purposes:

a) the operational and capital financial support needed for the normal requirements of the health system through global budgets which are subject to cost constraints, and
b) "thrust", "seed" and "investment" money required for health resources development.

## CONCLUSION

### FORCES WHICH SET THE PLANNING-ACTION PROCESS IN MOTION

Ontario experience does not represent utopia - we have a long way to go. It does, however, demonstrate an extensive and fairly prolonged attempt to improve the situation. Some of the forces which set the planning-action process in motion were:

1. The organisation of health services had not kept pace with advances in technology and defects created major barriers to efficient, effective and economic service. From an organisational point of view, we were back in the horse and buggy days. The education of the health disciplines was not blameless; in fact, the root of some of the problems originated from that source.
2. The increasing complexity of our arrangements and the fact that services were interwoven with education and research and interrelated with other features in our social and environmental structure made it imperative to adopt a planned and co-ordinated approach. Furthermore, it was considered that adequate progress could only be made by involving others in the process.
3. The providers of service, the public and government were questioning the adequacy of our health care arrangements. The public questioned lack of availability and accessibility, the remote attitude of many of our practitioners, shortages in personnel, excessive waiting time for service and in a few cases, competence. In other words, an informed public was interested and wished to be involved. Providers of service questioned their roles, pointed out defects in the system and this unrest was becoming more pronounced. Government was paying the bill and was directly involved as a managing agency of a major and complex industry.
4. Costs were escalating rapidly and requests for financial support were being questioned with increasing vigour. It was evident that if we did not put our own house in order, others would attempt to do it for us.

Other forces could be mentioned, but the four listed provided sufficient incentive for substantial action, with strong support and encouragement from most of those involved. The education of the health professions had to be viewed within the context of changing patterns for health care. This meant that these educational arrangements would be challenged in a major way as a participant in the development of a much better system.

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